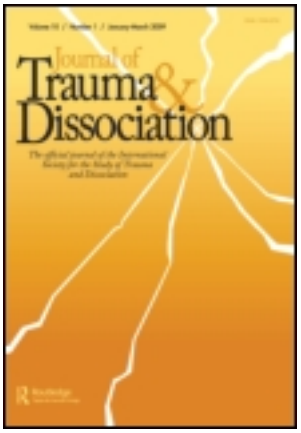

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Guidelines for Treating Dissociative Identity Disorder in Adults, Third Revision

International Society for the Study of Trauma and Dissociation

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Guidelines for Treating Dissociative Identity Disorder in Adults, Third Revision

INTERNATIONAL SOCIETY FOR THE STUDY
OF TRAUMA AND DISSOCIATION

FOREWORD

The International Society for the Study of Dissociation (ISSD), the former name of the International Society for the Study of Trauma and Dissociation (ISSTD), adopted the *Guidelines for Treating Dissociative Identity Disorder (Multiple Personality Disorder) in Adults* in 1994. However, the *Guidelines* must be responsive to developments in the field and require ongoing review. The first revision of the *Guidelines* was proposed by the ISSD's Standards of Practice Committee[1] and was adopted by the ISSD Executive Council in 1997 after substantial comment from the ISSD membership. The second revision of the *Guidelines* was requested and approved in 2005 based on the expertise of a task force of expert clinicians and researchers.[2] The current

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revision was undertaken by a new task force[3] in 2009 and 2010 after input from an open-ended survey of the membership.

The current revision of the *Guidelines* focuses specifically on the treatment of dissociative identity disorder (DID) and those forms of dissociative disorder not otherwise specified (DDNOS) that are similar to DID. It is intended as a practical guide to the management of adult patients and represents a synthesis of current scientific knowledge and informed clinical practice. There is a separate *Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents* (ISSD, 2004) available through the ISSTD and published in the *Journal of Trauma & Dissociation*. The American Psychiatric Association (2004) has published *Practice Guidelines for the Treatment of Patients with Acute Stress Disorder (ASD) and Posttraumatic Stress Disorder (PTSD)*, which may be relevant to the treatment of DID.

INTRODUCTION

Over the past 30 years, the diagnosis, assessment, and treatment of dissociative disorders have been enhanced by increased clinical recognition of dissociative conditions, the publication of numerous research and scholarly works on the subject, and the development of specialized diagnostic instruments. Peer-reviewed publications concerning dissociative disorders have appeared in the international literature from clinicians and investigators in at least 26 countries, including the United States, Canada, Puerto Rico, Argentina, The Netherlands, Norway, Switzerland, Northern Ireland, Great Britain, France, Germany, Italy, France, Sweden, Spain, Turkey, Israel, Oman, Iran, India, Australia, New Zealand, the Philippines, Uganda, China, and Japan. These publications include clinical case series and case reports; psychophysiological, neurobiological, and neuroimaging research; discussion of the development of diagnostic instruments; descriptions of open clinical trials and treatment outcome studies; and descriptions of treatment, treatment modalities, and treatment dilemmas. They consistently provide evidence that DID is a valid cross-cultural diagnosis that has validity comparable to or exceeding that of other accepted psychiatric diagnoses (Gleaves, May, & Cardeña, 2001). However, they also note that pathological alterations of identity and/or consciousness may present in other cultures as spirit possession and other culture-bound syndromes (Cardeña, Van Duijl, Weiner, & Terhune, 2009).

Key findings and generally accepted principles that reflect current scientific knowledge and clinical experience specific to the diagnosis and treatment of DID and similar forms of DDNOS are presented in the *Guidelines*. It should be understood that information in the *Guidelines* supplements, but does not replace, generally accepted principles of psychotherapy and

psychopharmacology. Treatment for DID should adhere to the basic principles of psychotherapy and psychiatric medical management, and therapists should use specialized techniques only as needed to address specific dissociative symptomatology.

The recommendations in the *Guidelines* are not intended to be construed as or to serve as a standard of clinical care. The practice recommendations reflect the state of the art in this field at the present time. The *Guidelines* are not designed to include all proper methods of care or to exclude other acceptable treatment interventions. Moreover, adhering to the *Guidelines* will not necessarily result in a successful treatment outcome in every case. Treatment should always be individualized, and clinicians must use their judgment concerning the appropriateness for a particular patient of a specific method of care in light of the clinical data presented by the patient and options available at the time of treatment.

EPIDEMIOLOGY, CLINICAL DIAGNOSIS, AND DIAGNOSTIC PROCEDURES

DID and dissociative disorders are not rare conditions. In studies of the general population, a prevalence rate of DID of 1% to 3% of the population has been described (Johnson, Cohen, Kasen, & Brook, 2006; Murphy, 1994; Ross, 1991; Şar, Akyüz, & Doğan, 2007; Waller & Ross, 1997). Clinical studies in North America, Europe, and Turkey have found that generally between 1% to 5% of patients in general inpatient psychiatric units; in adolescent inpatient units; and in programs that treat substance abuse, eating disorders, and obsessive-compulsive disorder may meet *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev. [*DSM–IV–TR*]; American Psychiatric Association, 2000a) diagnostic criteria for DID, particularly when evaluated with structured diagnostic instruments (Bliss & Jeppsen, 1985; Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006; Goff, Olin, Jenike, Baer, & Buttolph, 1992; Johnson et al., 2006; Karadag et al., 2005; Latz, Kramer, & Highes, 1995; McCallum, Lock, Kulla, Rorty, & Wetzel, 1992; Modestin, Ebner, Junghan, & Erni, 1995; Ross, Anderson, Fleisher, & Norton, 1991; Ross et al., 1992; Şar, Akyüz, et al., 2007; Saxe et al., 1993; Tutkun et al., 1998). Many of the patients in these studies had not previously been clinically diagnosed with a dissociative disorder.

Accurate clinical diagnosis affords early and appropriate treatment for the dissociative disorders. The difficulties in diagnosing DID result primarily from lack of education among clinicians about dissociation, dissociative disorders, and the effects of psychological trauma, as well as from clinician bias. This leads to limited clinical suspicion about dissociative disorders and misconceptions about their clinical presentation. Most clinicians have been taught (or assume) that DID is a rare disorder with a florid, dramatic

presentation. Although DID is a relatively common disorder, R. P. Kluft (2009) observed that "only 6% make their DID obvious on an ongoing basis" (p. 600). R. P. Kluft (1991) has referred to these moments of visibility as "windows of diagnosability" (also discussed by Loewenstein, 1991a). Instead of showing visibly distinct alternate identities, the typical DID patient presents a polysymptomatic mixture of dissociative and posttraumatic stress disorder (PTSD) symptoms that are embedded in a matrix of ostensibly nontrauma-related symptoms (e.g., depression, panic attacks, substance abuse, somatoform symptoms, eating-disordered symptoms). The prominence of these latter, highly familiar symptoms often leads clinicians to diagnose only these comorbid conditions. When this happens, the undiagnosed DID patient may undergo a long and frequently unsuccessful treatment for these other conditions.

Finally, almost all practitioners use the standard diagnostic interviews and mental status examinations that they were taught during professional training. Unfortunately, these standard interviews often do *not* include questions about dissociation, posttraumatic symptoms, or a history of psychological trauma. Because DID patients rarely volunteer information about dissociative symptoms, the absence of focused inquiry about dissociation prevents the clinician from diagnosing the disorder. Moreover, because most clinicians receive little or no training in dissociation and DID, they have difficulty recognizing the signs and symptoms of DID even when they occur spontaneously. The *sine qua non* for the diagnosis of DID is that the clinician must inquire about the symptoms of dissociation. The clinician's interview should be supplemented, as necessary, with screening instruments and structured interviews that assess the presence or absence of dissociative symptoms and dissociative disorders.

Diagnostic Criteria for DID

The *DSM–IV–TR* (American Psychiatric Association, 2000a) lists the following diagnostic criteria for DID (300.14; p. 529):

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
B. At least two of these identities or personality states recurrently take control of the person's behavior.
C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). Note: In

children, the symptoms are not attributable to imaginary playmates or other fantasy play.

In recent years, there has been debate about the diagnostic criteria for DID. Dell (2001, 2009a) has suggested that the high level of abstraction of the current diagnostic criteria, and the corresponding lack of concrete clinical symptoms, sharply reduces their utility for the average clinician and that a set of frequently appearing dissociative signs and symptoms would more accurately capture the typical presentations of DID patients. Others have argued that the current criteria are sufficient (D. Spiegel, 2001). Still others have suggested that dissociative disorders should be reconceptualized as belonging to a spectrum of trauma disorders, thereby emphasizing their intimate association with overwhelming and traumatic circumstances (Davidson & Foa, 1993; Ross, 2007; Van der Hart, Nijenhuis, & Steele, 2006).

Dissociation: Terminology and Definitions

The American Psychiatric Association (2000a) and the World Health Organization (1992) have characterized the dissociative disorders but have not fully described the nature of dissociation itself. Thus, the *DSM–IV–TR* states that "the essential feature of the Dissociative Disorders is a disruption in the usually integrated functions of consciousness, memory, identity, or perception" (American Psychiatric Association, 2000a, p. 519). There is some debate as to how broad or narrow the definition of *dissociation* should be. Putnam (1989) has described the process of dissociation as "a normal process that is initially used defensively by an individual to handle traumatic experiences [that] evolves over time into a maladaptive or pathological process" (p. 9). A number of authors (e.g., Cardeña, 1994; Holmes et al., 2005) have used the term descriptively to refer to failures to integrate information and self-attributions that should ordinarily be integrated, and to alterations of consciousness characterized by a sense of detachment from the self and/or the environment. A further subdivision is based on Pierre Janet's distinction between dissociative negative (i.e., a diminution or abolishment of a psychological process) and positive (i.e., the creation or exaggeration of a psychological process) symptoms. Dell and O'Neil's (2009) definition elaborated on the *DSM–IV*'s central concept of disruption:

> The essential manifestation of pathological dissociation is a partial or complete disruption of the normal integration of a person's psychological functioning. . . . Specifically, dissociation can unexpectedly disrupt, alter, or intrude upon a person's consciousness and experience of body, world, self, mind, agency, intentionality, thinking, believing, knowing, recognizing, remembering, feeling, wanting, speaking, acting, seeing,

> hearing, smelling, tasting, touching, and so on. . . . [T]hese disruptions . . . are typically experienced by the person as startling, autonomous intrusions into his or her usual ways of responding or functioning. The most common dissociative intrusions include hearing voices, depersonalization, derealization, "made" thoughts, "made" urges, "made" desires, "made" emotions, and "made" actions. (p. xxi)

Dissociative processes have various manifestations (Howell, 2005), many of them nonpathological. In particular, Dell (2009d) has argued that spontaneous, survival-related dissociation is part of a normal, evolution-selected, species-specific response; this dissociation is automatic and reflexive and is one part of a brief, time-limited, normal biological reaction that subsides as soon as the danger is over. The relationship between this dissociative response and the degree and nature of the dissociation seen in dissociative disorders is not yet adequately understood.

Alternate Identities: Conceptual Issues and Physiological Manifestations

The DID patient is a single person who experiences himself or herself as having separate alternate identities that have relative psychological autonomy from one another. At various times, these subjective identities may take executive control of the person's body and behavior and/or influence his or her experience and behavior from "within." Taken together, all of the alternate identities make up the identity or personality of the human being with DID.

Alternate identities have been defined in a number of ways. For example, Putnam (1989) described them as "highly discrete states of consciousness organized around a prevailing affect, sense of self (including body image), with a limited repertoire of behaviors and a set of state dependent memories" (p. 103). R. P. Kluft (1988b) stated,

> A disaggregate self state (i.e., personality) is the mental address of a relatively stable and enduring particular pattern of selective mobilization of mental contents and functions, which may be behaviorally enacted with noteworthy role-taking and role-playing dimensions and sensitive to intrapsychic, interpersonal, and environmental stimuli. It is organized in and associated with a relatively stable . . . pattern of neuropsychophysiologic activation, and has crucial psychodynamic contents. It functions both as a recipient, processor, and storage center for perceptions, experiences, and the processing of such in connection with past events and thoughts, and/or present and anticipated ones as well. It has a sense of its own identity and ideation, and a capacity for initiating thought processes and action. (pp. 55)

Many terms have been developed to describe the DID patient's subjective sense of self-states or identities. These include *personality*, *personality state*, *self-state*, *disaggregate self-state*, *alter*, *alter personality*, *alternate identity*, *part*, *part of the mind*, *part of the self*, *dissociative part of the personality*, and *entity*, among others (see Van der Hart & Dorahy, 2009). Because the *DSM–IV–TR* (American Psychiatric Association, 2000a) uses the term *alternate identity*, this term is used in the *Guidelines* for consistency.

Clinicians should attend to the unique, personal language with which DID patients characterize their alternate identities. Patients commonly refer to themselves as having parts, parts inside, aspects, facets, ways of being, voices, multiples, selves, ages of me, people, persons, individuals, spirits, demons, others, and so on. It can be helpful to use the terms that patients use to refer to their identities unless the use of these terms is not in line with therapeutic recommendations and/or, in the clinician's judgment, certain terms would reinforce a belief that the alternate identities are separate people or persons rather than a single human being with subjectively divided self-aspects.

Physiological differences among alternate identities. Case reports and studies using small groups of DID patients and controls who simulate different "alternate identities" have found significant physiologic differences in DID patients compared to controls that manifest in a variety of behavioral ways. These include differences in visual acuity, medication responses, allergies, plasma glucose levels in diabetic patients, heart rate, blood pressure readings, galvanic skin response, muscle tension, laterality, immune function, electroencephalography and evoked potential patterns, functional magnetic resonance imaging activation, and brain activation and regional blood flow using single photon emission computed tomography and positron emission tomography among others (Loewenstein & Putnam, 2004; Putnam, 1984, 1991b; Reinders et al., 2006; Şar, Ünal, Kiziltan, Kundakci, & Öztürk, 2001; Vermetten, Schmal, Lindner, Loewenstein, & Bremner, 2006). Overall, DID patients as a group show greater physiological *variability* between their identities compared to simulated identities in controls, rather than the kinds of reproducible differences found between different individuals.

Recent studies found significant psychobiological differences between different types of DID alternate identities as each identity in turn listened to a trauma script that only one identity subjectively experienced as a "personal" memory (Reinders et al., 2003, 2006). These differences involved subjective sensorimotor and emotional reactions, psychophysiological reactions such as pulse and blood pressure, as well as patterns of regional cerebral blood flow measured with positron emission tomography. These psychobiological differences were not found for the two different types of alternate identities as each identity in turn listened to a neutral, nontraumatic, autobiographical memory script.

Theories of the Development of DID

It is outside the scope of these *Guidelines* to provide a comprehensive discussion of current theories concerning the development of alternate identities in DID (see Loewenstein & Putnam, 2004, and Putnam, 1997, for a more complete discussion). Briefly, many experts propose a developmental model and hypothesize that alternate identities result from the inability of many traumatized children to develop a unified sense of self that is maintained across various behavioral states, particularly if the traumatic exposure first occurs before the age of 5. These difficulties often occur in the context of relational or attachment disruption that may precede and set the stage for abuse and the development of dissociative coping (Barach, 1991; Liotti, 1992, 1999). Freyd's theory of betrayal trauma posits that disturbed caregiver–child attachments and parenting further disrupt the child's ability to integrate experiences (Freyd, 1996; Freyd, DePrince, & Zurbriggen, 2001). Fragmentation and encapsulation of traumatic experiences may serve to protect relationships with important (though inadequate or abusive) caregivers and allow for more normal maturation in other developmental areas, such as intellectual, interpersonal, and artistic endeavors. In this way, early life dissociation may serve as a type of developmental resiliency factor despite the severe psychiatric disturbances that characterize DID patients (Brand, Armstrong, Loewenstein, & McNary, 2009).

Severe and prolonged traumatic experiences can lead to the development of discrete, personified behavioral states (i.e., rudimentary alternate identities) in the child, which has the effect of encapsulating intolerable traumatic memories, affects, sensations, beliefs, or behaviors and mitigating their effects on the child's overall development. Secondary structuring of these discrete behavioral states occurs over time through a variety of developmental and symbolic mechanisms, resulting in the characteristics of the specific alternate identities. The identities may develop in number, complexity, and sense of separateness as the child proceeds through latency, adolescence, and adulthood (R. P. Kluft, 1984; Putnam, 1997). DID develops during the course of childhood, and clinicians have rarely encountered cases of DID that derive from adult-onset trauma (unless it is superimposed on preexisting childhood trauma and preexisting latent or dormant fragmentation).

Another etiological model posits that the development of DID requires the presence of four factors: (a) the capacity for dissociation; (b) experiences that overwhelm the child's nondissociative coping capacity; (c) secondary structuring of DID alternate identities with individualized characteristics such as names, ages, genders; and (d) a lack of soothing and restorative experiences, which renders the child isolated or abandoned and needing to find his or her own ways of moderating distress (R. P. Kluft, 1984). The secondary structuring of the alternate identities may differ widely from patient to patient. Factors that may foster the development of highly

elaborate systems of identities are multiple traumas, multiple perpetrators, significant narcissistic investment in the nature and attributes of the alternate identities, high levels of creativity and intelligence, and extreme withdrawal into fantasy, among others. Accordingly, therapists who are experienced in the treatment of DID typically pay relatively limited attention to the overt style and presentation of the different alternate identities. Instead, they focus on the cognitive, affective, and psychodynamic characteristics embodied by each identity while simultaneously attending to identities collectively as a system of representation, symbolization, and meaning.

The theory of "structural dissociation of the personality," another etiological model, is based on the ideas of Janet and attempts to create a unified theory of dissociation that includes DID (Van der Hart et al., 2006). This theory suggests that dissociation results from a basic failure to integrate systems of ideas and functions of the personality. Following exposure to potentially traumatizing events, the personality as a whole system can become divided into an "apparently normal part of the personality" dedicated to daily functioning and an "emotional part of the personality" dedicated to defense. Defense in this context is related to psychobiological functions of survival in response to life threat, such as fight/flight, not to the psychodynamic notion of defense. It is hypothesized that chronic traumatization and/or neglect can lead to secondary structural dissociation and the emergence of additional emotional parts of the personality.

In short, these developmental models posit that DID does not arise from a previously mature, unified mind or "core personality" that becomes shattered or fractured. Rather, DID results from a failure of normal developmental integration caused by overwhelming experiences and disturbed caregiver–child interactions (including neglect and the failure to respond) during critical early developmental periods. This, in turn, leads some traumatized children to develop relatively discrete, personified behavioral states that ultimately evolve into the DID alternate identities.

Some authors claim that DID is caused by clinicians who believe strongly in DID and who implicitly and/or explicitly influence patients to enact symptoms of DID. According to this "sociocognitive" model,

> DID is a socially constructed condition that results from the therapist's cueing (e.g., suggestive questioning regarding the existence of possible alternate personalities), media influences (e.g., film and television portrayals of DID), and broader sociocultural expectations regarding the presumed clinical features of DID. For example, some proponents of the sociocognitive model believe that the release of the book and film *Sybil* in the 1970s played a substantial role in shaping conceptions of DID in the minds of the general public and psychotherapists. (Lilienfeld & Lynn, 2003, p. 117)

Despite these arguments, there is no actual research that shows that the complex phenomenology of DID can be created, let alone sustained over time, by suggestion, contagion, or hypnosis (D. W. Brown, Frischholz, & Scheflin, 1999; Gleaves, 1996; Loewenstein, 2007).

A number of lines of evidence support the trauma model for DID over the sociocognitive model. These include studies that demonstrate DID in children, adolescents, and adults with substantiated maltreatment with evidence that DID symptoms predated any interaction with clinicians (Hornstein & Putnam, 1992; Lewis, Yeager, Swica, Pincus, & Lewis, 1997), studies of psychophysiology and psychobiology as described above, and studies of the discriminant validity of the dissociative disorders using structured interview protocols, among many others. Furthermore, naturalistic studies have shown that DID patients report many symptoms that, based on research data characterizing DID, were previously unknown to the patients, the general culture, and even most clinicians (Dell, 2006b).

Diagnostic Interviewing

A careful clinical interview and thoughtful differential diagnosis can usually lead to the correct diagnosis of DID (Coons, 1984). Assessment for dissociation should be conducted as a part of every diagnostic interview, given the fact that dissociative disorders are at least as common, if not more common, than many other psychiatric disorders that are routinely considered in psychiatric evaluations. At a minimum, the patient should be asked about episodes of amnesia, fugue, depersonalization, derealization, identity confusion, and identity alteration (Steinberg, 1995). Additional useful areas of inquiry include questions about spontaneous age regressions; autohypnotic experiences; hearing voices (Putnam, 1991a); passive-influence symptoms such as "made" thoughts, emotions, or behaviors (i.e., those that do not feel attributable to the self; Dell, 2009c; R. P. Kluft, 1987a); and somatoform dissociative symptoms such as bodily sensations related to strong emotions and past trauma (Nijenhuis, 1999). Clinicians should also be alert to behavioral manifestations of dissociation, such as posture, presentation of self, dress, fixed gaze, eye fluttering, fluctuations in style of speech, interpersonal relatedness, skill level, and sophistication of cognition (Armstrong, 1991, 2002; Loewenstein, 1991a). Loewenstein (1991a) has described an office mental status examination that inquires about many symptoms of DID, including evidence of alternate identities, amnesia, autohypnotic phenomena, PTSD, somatoform symptoms, and affective symptoms.

The process of diagnosing severe dissociative disorders is complicated by patients' early trauma and attachment difficulties and the resultant mistrust of others, especially authority figures. Traumatized patients may be very reluctant to reveal an inner, hidden world to a clinician who may be seen as such a figure (Brand, Armstrong, & Loewenstein, 2006). Furthermore,

the diagnostic process demands that the person reflect upon and report experiences that have been dissociated because they elicit such strong, negative, and contradictory feelings. In short, many dissociative patients are understandably reluctant or unable to acknowledge and reveal their inner experiences. Unless clinicians take the time to develop a collaborative relationship based on increased levels of trust, the data from diagnostic interviews and self-report measures are unlikely to yield valid, useful information (Armstrong, 1991; Brand, Armstrong, et al., 2006).

Clinicians should bear in mind that some persons with DID do not realize (or do not acknowledge to themselves) that their internal experience is different from that of others. In keeping with the view that dissociation may serve as a defense against uncomfortable realities, the presence of alternate identities and other dissociative symptoms is commonly denied and disavowed by persons with DID. This kind of denial is consistent with the defensive function of disavowing both the trauma and its related emotions and the subsequent dissociated sense of self. Not surprisingly, persons with DID frequently present with avoidant personality disorder and as depleted and depressed (see Cardeña & Spiegel, 1996).

DID is nearly universally associated with an antecedent history of significant traumatization—most often first occurring in childhood (Putnam, 1997; Putnam, Guroff, Silberman, Barban, & Post, 1986). Accordingly, the diagnostic process should include an effort to assess the patient's trauma history. However, clinicians should use careful clinical judgment about how aggressively to pursue details of traumatic experiences during initial interviews, especially when those experiences seem to be poorly or incompletely remembered, or if remembering or recounting the trauma appears to overwhelm the individual's emotional capacities. Prematurely eliciting details of a trauma history may evoke a florid decompensation (i.e., severe posttraumatic and dissociative symptoms). Because of their dissociative amnesia, DID patients often provide a fragmented and incoherent history early in treatment; a more complete personal history typically emerges over time.

DDNOS

A substantial proportion of the dissociative cases encountered in clinical settings receive a diagnosis of DDNOS. Many of these DDNOS cases are well described by the *DSM–IV–TR* Example 1 of DDNOS: "Clinical presentations similar to dissociative identity disorder that fail to meet the full criteria for this disorder" (American Psychiatric Association, 2000a, p. 532). There appear to be two major groupings of such DDNOS-1 cases: (a) full-blown DID cases whose diagnosis has not yet been confirmed (via the unambiguous manifestation of alternate identities) and (b) complex dissociative cases with some internal fragmentation and/or infrequent incidents of amnesia (Dell, 2009b). Patients in this latter group of DDNOS-1 are

"almost-DID." DDNOS-1 patients are typically subject to DID-like disruptions in their functioning caused by switches in self-states and intrusions of feelings and memories into consciousness. Because these latter phenomena are often more subtle than cases with florid DID, it may require more skill and expertise on the part of clinicians to discern their presence. In terms of treatment, however, the expert consensus is that DDNOS-1 cases—whether they are as-yet-undiagnosed DID or almost-DID—benefit from many of the treatments that have been designed for DID.

Measures of Dissociation

Three classes of instruments that assess dissociative symptoms or diagnoses are discussed here: comprehensive clinician-administered structured interviews, comprehensive self-report instruments, and brief self-report screening instruments. Several other measures of dissociation are used primarily for research and are not discussed as part of these *Guidelines*, which are designed to be clinically oriented.

Comprehensive clinician-administered structured interviews. The Structured Clinical Interview for *DSM–IV* Dissociative Disorders–Revised (SCID-D-R; Steinberg, 1994a, 1994b, 1995) is a 277-item interview that assesses five symptoms of dissociation: amnesia, depersonalization, derealization, identity confusion, and identity alteration. Most items have follow-up questions that ask for a description of the experience, specific examples, and the frequency of the experience and its impact on social functioning and work performance. The SCID-D-R diagnoses the five *DSM–IV* dissociative disorders; it also yields a score for each of the five dissociative symptoms and a total score based on the frequency and intensity of symptoms. The SCID-D-R takes 45 to 180 min or more to administer. The interviewer, whether a clinician or a trained technician, must have considerable familiarity with dissociative symptoms.

The Dissociative Disorders Interview Schedule (DDIS; Ross, 1997; Ross et al., 1989, 1990) is a 132-item structured interview that assesses the symptoms of the five *DSM–IV* dissociative disorders, somatization disorder, borderline personality disorder, and major depressive disorder. The DDIS also assesses substance abuse, Schneiderian first-rank symptoms, trance, childhood abuse, secondary features of DID, and supernatural/paranormal experiences. The instrument usually takes 30 to 60 min to administer. The DDIS provides diagnoses and the number of items that were endorsed in each section of the interview but does not assess the frequency or severity of symptoms.

Comprehensive self-report instruments. The Multidimensional Inventory of Dissociation (MID; Dell, 2006a) is a multiscale diagnostic instrument designed to comprehensively assess dissociative phenomena. The MID is a 218-item instrument with 168 dissociation items and 50 validity items.

The MID takes 30 to 90 min to complete. The MID and its Excel®-based scoring program (freely available to mental health professionals) generates both scale scores and diagnoses (i.e., DID, DDNOS, PTSD, and severe borderline personality disorder). The MID measures 23 dissociative symptoms and six response sets that serve as validity scales. The MID's 168 dissociation items have 12 first-order factors (self-confusion, angry intrusions, dissociative disorientation, amnesia, distress about memory problems, experience of alternate identities, derealization/depersonalization, persecutory intrusions, trance, flashbacks, body symptoms, gaps in autobiographical memory) and one second-order factor (pathological dissociation; Dell & Lawson, 2009).

Brief self-report instruments. Brief screening instruments are designed only for screening and should not be used by themselves either to rule in or rule out the diagnosis of a dissociative disorder.

The Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986, 1993) has been used more widely in both research and clinical practice than any other measure of dissociation. It has been translated into many languages from its original English. The DES is a 28-item self-report instrument whose items tap primarily absorption, imaginative involvement, depersonalization, derealization, and amnesia. The DES-Taxon uses eight questions from the DES that are most closely identified with a taxon (class) of individuals who demonstrate "pathological dissociation" (Waller, Putnam, & Carlson, 1996).

The Dissociation Questionnaire (DIS-Q; Vanderlinden, 1993; Vanderlinden, Van Dyck, Vandereycken, Vertommen, & Verkes, 1993) is a 63-item self-report instrument. The initial item pool from which the DIS-Q was developed included the DES, the Perceptual Alteration Scale (Sanders, 1986), and the Questionnaire of Experiences of Dissociation (Riley, 1988), with additional items that were derived from interviews with dissociative patients. The DIS-Q measures identity confusion and fragmentation, loss of control, amnesia, and absorption. Developed in Belgium and The Netherlands, the DIS-Q is more commonly used by European than North American clinicians and researchers.

The Somatoform Dissociation Questionnaire-20 (SDQ-20) is a 20-item self-report instrument that uses a 5-point Likert scale (Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1996, 1998; Nijenhuis et al., 1999). Based on the clinical/descriptive work of Janet (1889), the SDQ-20 is explicitly conceptualized as a measure of somatoform dissociation. The SDQ-20 items address tunnel vision, auditory distancing, muscle contractions, psychogenic blindness, difficulty urinating, insensitivity to pain, psychogenic paralysis, non-epileptic seizures, and so on. A shorter version, the SDQ-5, is composed of five items from the SDQ-20 (Nijenhuis, 1999). The SDQ-5 was developed as a screening instrument for dissociative disorders and correlates well with findings of the longer inventory.

Other Psychological Tests

Some measures commonly used in psychological testing (e.g., the Rorschach Inkblot Test, Minnesota Multiphasic Personality Inventory–2, Wechsler Adult Intelligence Scale–Revised, Millon Clinical Multiaxial Inventory–III) can provide understanding of the patient's personality structure and may yield information useful in making the differential diagnosis between disorders often confused with DID, such as borderline personality disorder and psychotic disorders (Armstrong, 1991, 2002; Brand, Armstrong, et al., 2009). For example, on the Rorschach, DID patients can be distinguished from psychotic patients by the DID patients' significant traumatic intrusions alongside better reasoning and greater cognitive complexity (Brand, Armstrong, et al., 2009). DID patients can also be distinguished on the Rorschach from borderline personality disorder patients by DID patients' greater capacity for collaborative relationships and self-reflection, more accurate perceptions, and more logical thinking (Brand, Armstrong, et al., 2009). However, commonly used psychological tests were *not* designed to detect dissociative disorders and may lead to misdiagnosis when the evaluator (a) is not familiar with the typical responses of dissociative patients on these tests, (b) relies primarily on scoring scales not normed for a dissociative population, (c) does not administer additional dissociation-specific tests (such as structured clinical interviews), and (d) does not inquire specifically about dissociative symptoms during the clinical or testing interview.

Differential Diagnosis and Misdiagnosis of DID

Clinicians should be alert to both false positive and false negative diagnoses of DID. It is important that clinicians appreciate the similarities and differences between the symptoms of dissociative disorders and other frequently encountered disorders. Bipolar, affective, psychotic, seizure, and borderline personality disorders are among the common false negative diagnoses of patients with DID and DDNOS. False negative diagnoses of DID readily occur when the assessment interview does not include questions about dissociation and trauma or focuses on more evident comorbid conditions, and when evaluators have failed to attend to critical process issues such developing a working alliance.

Conversely, clinicians who specialize in dissociative disorders must be able to recognize and diagnose nondissociative disorders so that they do not incorrectly diagnose DID or fail to identify the presence of true comorbid conditions. Dissociative symptoms are central in other dissociative disorders and PTSD and can be part of the clinical presentation of patients with somatization disorder, panic disorder, and even psychosis. It should not be assumed that symptoms such as amnesia or even identity "fragmentation" automatically connote a diagnosis of DID. The identity problems that occur in personality-disordered patients may occasionally be misdiagnosed as a

symptom of DID. Mood changes in bipolar patients, especially those with comorbid PTSD, have been confused with DID. Some psychotic patients with delusions of being inhabited by other people may be misdiagnosed as DID. In addition, some patients may have dissociative symptoms but a nondissociative primary diagnosis. For example, a subgroup of patients with a schizophrenic disorder and a history of childhood trauma have concurrent dissociative symptoms (Ross & Keyes, 2004; Şar et al., 2010). Personality-disordered patients who have dissociative symptoms and identity disturbances may be misdiagnosed as DID. For example, "transient stress related . . . severe dissociative symptoms" (p. 710) and identity disturbance are *DSM–IV–TR* criterion symptoms for borderline personality disorder. Many borderline patients, as well as other personality-disordered patients, have histories of childhood maltreatment. When these patients are subjected to premature, intense exploration of trauma memories, they may have an increased sense of identity fragmentation that can be misdiagnosed as DID. Studies comparing personality disorder patients and patients with DID have shown that careful clinical assessment; use of diagnostic tests such as the DES, the SCID-D, and the MID; and psychological assessment may be helpful in the differential diagnosis (Boon & Draijer, 1993; Brand, Armstrong, et al., 2009; Draijer & Boon, 1999).

Inexperienced clinicians may also confuse a patient's investment in a metaphorical "inner child" or similar phenomena with clinical DID. Clinicians who are poorly trained in hypnosis may confuse hypnotic phenomena, such as the production of "ego states," with clinical DID (Watkins & Watkins, 1997). In some instances, these problems can be compounded by patient's desire to have a more "interesting" or elaborate disorder, resulting in the patient coming to believe that he or she has DID. For example, Boon and Draijer described "imitative DID," particularly in patients with personality disorders. Here, the patient, concerned others, and even the therapist strongly believe in the patient's identity as having DID (Boon & Draijer, 1993; Draijer & Boon, 1999). Among other symptoms, patients with this kind of pseudo-DID tend to be characterized by an enthusiastic embrace and display of their "identities" that is contrary to typical DID patients' pervasive pattern of disavowal—of dissociated aspects of themselves, of overwhelming trauma, and of the diagnosis of DID—at least during initial phases of treatment.

As with any psychiatric condition, a presentation of DID may be factitious or malingered (Coons, 1991; Coons & Milstein, 1994; Draijer & Boon, 1999; R. P. Kluft, 1987c; Thomas, 2001). Clinicians should be alert to this concern, especially in situations where there is strong motivation to simulate an illness (e.g., pending legal charges, civil litigation, and/or disability or compensation determinations). Research studies have shown that the SCID-D, the MID, and other diagnostic inventories can be useful in differentiating feigned DID from bona fide DID patients (Brand, McNary, Loewenstein,

Kolos, & Barr, 2006). Especially in a forensic setting, the comprehensive evaluation of possible factitious and/or malingered DID may include (a) a comprehensive clinical interview, (b) review of all available clinical documentation and collateral information, (c) standardized measures of dissociation and PTSD, (d) standard psychological tests (e.g., the Millon Clinical Multiaxial Inventory–II [Millon, 1997] or the Rorschach), and (e) measures of malingering (e.g., Structured Interview of Reported Symptoms; Rogers, Bagby, & Dickens, 1992). However, Brand, McNary et al. (2006) found that some individuals with DID had elevated scores on some Structured Interview of Reported Symptoms subscales because the test items include a number of common dissociative symptoms such as depersonalization.

Somatoform Comorbidity in DID

Historically speaking, somatoform disorders and dissociative disorders have been linked through the concept of hysteria and until the *DSM–III* were conceptualized as having similar underlying processes or mechanisms. The *DSM–III* committee placed somatoform and dissociative disorders in separate categories, although this decision has been challenged (R. J. Brown, Cardeña, Nijenhuis, Şar, & Van der Hart, 2007). The International Classification of Diseases–9 (World Health Organization, 1977), however, continued to conceptualize these disorders as sharing an underlying relationship. The same is true for the International Classification of Diseases–10 (World Health Organization, 1992), which includes dissociative disorders of movement and sensation rather than conversion disorders. High rates of somatization and somatoform disorders are found in DID patients. Nijenhuis (1999) has characterized many of these types of symptoms as somatoform dissociation. Common somatoform symptoms in DID patients are quite varied and can include abdominal pain, pelvic pain, joint pain, face and head pain, lump in the throat, back pain, non-epileptic seizures, and pseudo-asthma, among others. Somatoform dissociation may explain the high rates of childhood maltreatment, particularly sexual abuse, found in patients with somatization disorder (Briquet's Syndrome), somatoform pain disorder, hypochondriasis, and conversion disorder, particularly non-epileptic seizures (Barsky, Wool, Barnett, & Cleary, 1994; Bowman & Markand, 1996; Goodwin & Attias, 1999; Litwin & Cardeña, 2000; Loewenstein, 1990, 2002; Loewenstein & Goodwin, 1999; McCauley et al., 1997; Morrison, 1989; Şar, Akyüz, Kundakci, Kiziltan, & Dogan, 2004; Saxe et al., 1994).

Treatment considerations. Some DID patients have an uncanny ability to produce realistic conversion (i.e., somatoform dissociative symptoms that mimic serious medical problems, including seizures, severe headaches, neurological problems, breathing difficulties, etc.). In addition, somatoform elaboration may be superimposed on medical illness.

Particularly in cultures outside of North America, it is common for DID patients to present to emergency departments with somatoform dissociative (conversion) symptoms such as pseudo-epilepsy (Şar, Koyuncu, et al., 2007). If medical causes can be ruled out, useful psychotherapy interventions include accessing and working with the alternate identities that either embody or control the somatoform symptoms and/or resolving conflicts among identities that have resulted in these symptoms. At times, short-term hospitalization may be needed to rule out severe medical illness, stabilize debilitating physical symptoms, and initiate psychotherapy. Some somatoform symptoms may be better conceptualized as somatoform flashbacks, the dissociated somatic component of a trauma memory (sometimes referred to as "body memories"; see Braun, 1988). Therapeutic efforts to verbally express the content of these symptoms can ameliorate somatoform flashback symptoms—at times surprisingly rapidly. Sensorimotor psychotherapy, which has been reported to be a helpful adjunctive treatment for DID, can also be useful in resolving somatoform symptoms (Ogden, Minton, & Pain, 2006). Overall, these interventions can reduce inappropriate medical or pharmacological treatments, contribute to improved patient well-being and functioning, as well as reduce costs for inappropriate medical care for somatoform symptoms.

Some DID patients may be preoccupied with somatoform pain syndromes and take high doses of narcotic analgesics with limited response. Other DID patients dissociate pain for long periods of time, thus delaying medical care until severe complications have occurred (e.g., even metastatic cancer). DID patients have varying utilization patterns of medical care, with some DID patients using health resources at a higher rate than the general population and others being phobic of seeking any medical care at all. The latter may be due to reenactment of childhood patterns of medical neglect, intrusive symptoms related to reported medical traumas or abuse by medical professionals, and/or shame and PTSD-based avoidance of showing or having one's body touched. There are complex issues that need to be addressed in evaluating and treating the somatic problems of the DID patient (see Goodwin & Attias, 1999). In brief, the treating clinician must educate the patient about reasonable health care and be an advocate in helping the patient to seek out appropriate medical care.

In some instances, it may be useful for mental health professionals to provide consultation to medical practitioners to help with the DID patient's posttraumatic reactivity to medical practitioners or procedures. Also, consultation can be helpful when the patient presents with extensive somatization that can complicate or impede accurate medical diagnosis and care. In addition, the treating psychiatrist often has a role in interfacing with the medical care community to help the patient get needed services as well as to help rein in the pressure for more and more tests or interventions when there is no clear-cut major new problem.

Many DID patients may have particular difficulties with medical procedures or treatments. The therapist may need to educate medical personnel about dissociation and forewarn them of possible difficulties. Careful preparation is especially important for any intervention that is intrusive, such gynecologic procedures, anesthesia, and/or surgery. The therapist may need to work with alternate identities who deny ownership of "the body," assert that they live in a different body, claim that their body is a different chronological age, and so on, in order for the patient to accept appropriate medical care.

TREATMENT GOALS AND OUTCOME

Integrated Functioning as the Goal of Treatment

Although the DID patient has the subjective experience of having separate identities, it is important for clinicians to keep in mind that the patient is not a collection of separate people sharing the same body. The DID patient should be seen as a whole adult person, with the identities sharing responsibility for daily life. Clinicians working with DID patients generally must hold the whole person (i.e., system of alternate identities) responsible for the behavior of any or all of the constituent identities, even in the presence of amnesia or the sense of lack of control or agency over behavior (see Radden, 1996).

Treatment should move the patient toward better integrated functioning whenever possible. In the service of gradual integration, the therapist may, at times, acknowledge that the patient experiences the alternate identities as if they were separate. Nevertheless, a fundamental tenet of the psychotherapy of patients with DID is to bring about an increased degree of communication and coordination among the identities.

In most DID patients, each identity seems to have its "own" first-person perspective and sense of its "own" self, as well as a perspective of other parts as being "not self." The identity that is in control usually speaks in the first person and may disown other parts or be completely unaware of them. Switches among identities occur in response to changes in emotional state or to environmental demands, resulting in another identity emerging to assume control. Because different identities have different roles, experiences, emotions, memories, and beliefs, the therapist is constantly contending with their competing points of view.

Helping the identities to be aware of one another as legitimate parts of the self and to negotiate and resolve their conflicts is at the very core of the therapeutic process. It is countertherapeutic for the therapist to treat any alternate identity as if it were more "real" or more important than any other. The therapist should not "play favorites" among the alternate identities or exclude apparently unlikable or disruptive ones from the therapy (although

such steps may be necessary for a limited period of time at some stages in the treatment of some patients to provide for the safety and stability of the patient or the safety of others). The therapist should foster the idea that all alternate identities represent adaptive attempts to cope or to master problems that the patient has faced. Thus, it is countertherapeutic to tell patients to ignore or "get rid" of identities (although it is acceptable to provide strategies for the patient to resist the influence of destructive identities, or to help control the emergence of certain identities at inappropriate circumstances or times).

It is countertherapeutic to suggest that the patient create additional alternate identities, to name identities when they have no names (although the patient may choose names if he or she wishes), or to suggest that identities function in a more elaborated and autonomous way than they already are functioning.

A desirable treatment outcome is a workable form of integration or harmony among alternate identities. Terms such as *integration* and *fusion* are sometimes used in a confusing way. *Integration* is a broad, longitudinal process referring to all work on dissociated mental processes throughout treatment. R. P. Kluft (1993a) defined *integration* as an

> ongoing process of undoing all aspects of dissociative dividedness that begins long before there is any reduction in the number or distinctness of the identities, persists through their fusion, and continues at a deeper level even after the identities have blended into one. It denotes an ongoing process in the tradition of psychoanalytic perspectives on structural change. (p. 109)

Fusion refers to a point in time when two or more alternate identities experience themselves as joining together with a complete loss of subjective separateness. *Final fusion* refers to the point in time when the patient's sense of self shifts from that of having multiple identities to that of being a unified self. Some members of the 2010 Guidelines Task Force have advocated for the use of the term *unification* to avoid the confusion of early fusions and final fusion.

R. P. Kluft (1993a) has argued that the most stable treatment outcome is final fusion—complete integration, merger, and loss of separateness—of all identity states. However, even after undergoing considerable treatment, a considerable number of DID patients will not be able to achieve final fusion and/or will not see fusion as desirable. Many factors can contribute to patients being unable to achieve final fusion: chronic and serious situational stress; avoidance of unresolved, extremely painful life issues, including traumatic memories; lack of financial resources for treatment; comorbid medical disorders; advanced age; significant unremitting *DSM* Axis I and/or Axis II comorbidities; and/or significant narcissistic investment in the alternate

identities and/or DID itself; among others. Accordingly, a more realistic long-term outcome for some patients may be a cooperative arrangement sometimes called a "resolution"—that is, sufficiently integrated and coordinated functioning among alternate identities to promote optimal functioning. However, patients who achieve a cooperative arrangement rather than final fusion may be more vulnerable to later decompensation (into florid DID and/or PTSD) when sufficiently stressed.

Even after final fusion, additional work to integrate the patient's residual dissociated ways of thinking and experiencing may continue. For instance, the therapist and patient might need to work on fully integrating an ability that was previously held by one alternate identity, or the patient may need to learn what his or her new pain threshold is, or how to integrate all the dissociated ages into one chronological age, or how to regauge appropriate and healthy exercise or exertion levels for his or her age. Traumatic and stressful material also may need to be reworked from this new unified perspective.

Treatment Outcome, Treatment Trajectories, and Cost Effectiveness for DID

Although studies of treatment for DID date back more than a century (Janet, 1919; Prince, 1906), rigorous research on the treatment of DID is still in its infancy. In their review of treatment studies of a variety of dissociative disorders, Brand, Classen, McNary, and Zaveri (2009) identified several factors that complicate research in this area, including the lengthy treatment that is usually required and the pragmatic need for a flexible treatment approach to managing the complex clinical situations of DID patients. Despite the challenges, DID treatment has been explored through case studies, case series, cost-efficacy studies, and naturalistic outcome studies of therapeutic effectiveness. Taken as a whole, this body of work provides evidence of effective treatments for DID and a wide range of associated symptoms.

In The Netherlands, a chart review study of 101 dissociative disorder patients in outpatient treatment for an average of 6 years found that clinical improvement was related to the intensity of the treatment; more comprehensive therapies had better outcomes (Groenendijk & Van der Hart, 1995). Systematically collected outcome data from case series and treatment studies indicated that 16.7% to 33% of those DID patients achieved full integration (i.e., final fusion; Coons & Bowman, 2001; Coons & Sterne, 1986; Ellason & Ross, 1997).

Two studies of the outcomes and cost-efficacy of DID treatment had concordant findings suggesting that outcome depends on patients' clinical characteristics (Loewenstein, 1994; Loewenstein & Putnam, 2004). Relatively high-functioning DID patients responded to treatment more quickly. Nevertheless, treatment gains—though more limited in scope—were

unmistakably evident in patients with a wide array of comorbid Axis I and II conditions and in patients with long psychiatric histories.

In Brand, Classen, McNary, et al.'s (2009) dissociative disorders treatment review, eight studies yielded sufficient outcome data to be included in a small meta-analysis. These studies provide preliminary evidence that treatment is effective at reducing a range of symptoms associated with dissociative disorders, including depression, anxiety, Axis I and Axis II diagnoses, and dissociative symptoms.

A large international naturalistic study supports the benefits of psychological therapy for DID (Brand, Classen, Lanius, et al., 2009). This longitudinal study is currently following 292 therapists from around the world and their DID or DDNOS patients ($N = 280$). Cross-sectional results of baseline data suggest that those further on in treatment for DID/DDNOS had fewer dissociative, posttraumatic stress, and general psychiatric symptoms compared with patients early in their treatment (Brand, Classen, Lanius, et al., 2009). Those in the later stages of therapy also showed significantly better adaptive functioning and Global Assessment of Functioning scores as rated by therapists. Patient reports indicated that those in the later stage of therapy were more likely to be engaged in volunteer work or study and had fewer hospitalizations.

PHASE-ORIENTED TREATMENT APPROACH

Over the past two decades, the consensus of experts is that complex trauma-related disorders—including DID—are most appropriately treated in sequenced stages. As early as the late 19th century, Pierre Janet advocated a phase-oriented treatment for dissociative disorders (see D. Brown, Scheflin, & Hammond, 1998; Van der Hart, Brown, & Van der Kolk, 1989). The most common structure across the field consists of three phases or stages:

1. Establishing safety, stabilization, and symptom reduction;
2. Confronting, working through, and integrating traumatic memories; and
3. Identity integration and rehabilitation.

(see D. Brown et al., 1998; Chu, 1998; Courtois, 1999; Courtois, Ford, & Cloitre, 2009; Herman, 1992b; R. P. Kluft, 1993a; Steele, Van der Hart, & Nijenhuis, 2001, 2005; Van der Hart et al., 2006; Van der Hart, Van der Kolk, & Boon, 1998). The writings of R. P. Kluft (1993a), Steele et al. (2005), and Van der Hart et al. (2006), among others, address many of the specific considerations in the phase-oriented treatment of DID and other dissociative disorders.

Complex PTSD (Ford & Courtois, 2009; Herman, 1992a, 1993; Van der Kolk, Roth, Pelcovitz, & Mandel, 1993) is a construct that fits many DID

patients (Courtois, 2004). These patients commonly have been repeatedly traumatized, typically beginning in childhood and spanning several developmental periods. In addition to PTSD symptoms, persons with complex PTSD have major difficulties with dissociation, affect regulation, body image distortions, self-injury, chronic suicidality, and somatization. They may have substantial relational pathologies, including problems with trust and revictimization in violent or abusive relationships. They often view the world as dangerous and traumatizing and tend to see themselves as shameful, damaged, and responsible for their own abuse. Treatment for complex PTSD resembles that of DID in that it is often of longer duration, is multimodal and relatively eclectic, and is designed to address the multitude of clinical difficulties with which these patients struggle (Chu, 1998; Courtois et al., 2009).

A phase-oriented treatment model for DID is briefly discussed here. The phases of treatment describe the dominant focus of the therapeutic work during each stage; overall, they assist the DID patient in developing safety, stability, and greater adaptation to daily life. Work with traumatic experiences is carefully titrated and paced. For instance, in the stabilization phase, treatment may focus at times on traumatic memories, but from a distanced and cognitive perspective. In the middle phase of treatment, stabilization and symptom management is often still necessary to prevent patients from becoming overwhelmed by the nature of their work on traumatic memories. Attention to rehabilitation and better overall life adaptation is essential throughout any treatment process and should occur in each phase of treatment.

Phase 1: Establishing Safety, Stabilization, and Symptom Reduction

In the initial phase of treatment, emphasis should be placed on establishing a therapeutic alliance, educating patients about diagnosis and symptoms, and explaining the process of treatment. The goals of Phase 1 treatment include maintaining personal safety, controlling symptoms, modulating affect, building stress tolerance, enhancing basic life functioning, and building or improving relational capacities. Maintaining a sound treatment frame in the context of a therapeutic holding environment is absolutely critical to establishing a stable therapy that maximizes the likelihood of a successful outcome.

Safety issues and symptom management. Safety issues and symptom management should be addressed in a comprehensive and direct manner. Other treatment issues may need to be put on hold until safety is established. Interventions should include (a) education about the necessity for safety for the treatment to succeed; (b) an assessment of the function(s) of unsafe and/or risky behaviors and urges; (c) development of positive and constructive behavioral repertoires to remain safe; (d) identification of

alternate identities who act unsafely and/or control unsafe behaviors; (e) development of agreements between alternate identities to help the patient maintain safety; (f) use of symptom management strategies such as grounding techniques, crisis planning, self-hypnosis, and/or medications to provide alternatives to unsafe behaviors; (g) management of addictions and/or eating disorders that may involve referral to adjunctive specialized treatment programs; (h) involvement of appropriate agencies if there is a question about whether the patient is abusive or violent toward children, vulnerable adults, or others (following the laws of the jurisdiction in which the clinician practices); (i) helping the patient with appropriate resources for self-protection from domestic violence; and (j) insisting that the patient seek treatment at a more restrictive level of care, including hospitalization, as necessary to prevent harm to self or others (Brand, 2002).

Suicidal and/or self-injurious behaviors are exceptionally common among DID patients; studies have shown that 67% of dissociative disorders patients report a history of repeated suicide attempts and 42% report a history of self-harm (Foote, Smolin, Neft, & Lipschitz, 2008; Putnam et al., 1986; Ross & Norton, 1989b). In addition, borderline personality disorder is diagnosed in 30% to 70% of the DID population (Boon & Draijer, 1993; Dell, 1998; Ellason, Ross, & Fuchs, 1996; Horevitz & Braun, 1984; Korzewa, Dell, Links, Thabane, & Fougere, 2009; Ross et al., 1991; Şar et al., 2003), and 60% to 70% of borderline patients make suicide attempts (Gunderson, 2001). However, many DID experts believe that severe dysregulated PTSD and dissociative symptoms account for global instability that leads to this high rate of borderline personality disorder diagnosis, with only a minority of DID patients meeting full borderline personality disorder criteria after definitive stabilization (Brand, Armstrong, et al., 2009; Loewenstein, 2007; Ross, 1997). Recent studies have also shown that childhood maltreatment in general (Arnow, 2004) and childhood sexual abuse in particular (Van der Kolk, Perry, & Herman, 1991) are associated with an increased risk of suicidal and parasuicidal behavior.

DID patients usually give a history of having been abused or having had their safety disregarded throughout their early lives. They tend to reenact these behaviors, venting their aggression, shame, fear, horror, and other overwhelming affects onto themselves through self-injurious and destructive behaviors, often in identification with the aggressor. Accordingly, one major cornerstone of treatment is to help patients to minimize behaviors that are dangerous to themselves or others (especially minor children) or that make them vulnerable to revictimization by others. These include suicidal or parasuicidal behaviors, alcohol or substance abuse, enmeshment in violent or exploitive relationships, eating disorder symptoms, violence or aggression, and risk-taking behaviors.

Without attention to the myriad safety problems of DID patients, little will be accomplished in the treatment. Safety problems often manifest as

overt or covert behaviors that can best be understood as self-regulatory or even self-soothing strategies that are logically related to the patient's history of neglect and trauma and his or her attempts to cope with these. Accordingly, they are usually best acknowledged in therapy as acquired modes of coping with immense pain and best treated as adaptations to be shaped in a different direction rather than as "bad" behaviors to be eliminated. Nonetheless, the therapist must address these behaviors as currently dysfunctional and insist that the patient ally with a stance of "nonabusive values" to self or others (Loewenstein, 1993).

As part of the emphasis on safety and self-management, the clinician will commonly develop "safety agreements" with the patient's alternate identity system to provide a structure for the patient to reduce unsafe behaviors. From both a clinical and medico-legal perspective, these agreements are not a substitute for the clinician's judgment about the patient's safety. Safety agreements must be interpreted in the total context of the patient's clinical situation and should be reviewed on a regular basis with the patient. Clinicians should recognize that no language is free of loopholes, should insist that patients comply with the spirit of the agreement, and must attend to the "expiration" dates included in some safety agreements. In addition, clinicians should not bear the burden of making an agreement with each alternate identity. Instead, strategies should be developed (e.g., "talking through") to make sure that all alternate identities acknowledge that they are bound by the agreement. The clinician should always insist on more restrictive treatment alternatives if, in his or her clinical judgment, the patient is unsafe.

Safety agreements may be best conceptualized as delaying or temporizing strategies that, over time, help patients to understand their ambivalence about safety and to realize that they have control over personal safety, as well as help them more effectively mobilize their efforts toward safety. Discussion of controlling unsafe behaviors frequently brings a wealth of crucial material into the therapy concerning the alternate identity system, the patient's history, transference issues (especially traumatic transference themes), and dominant ideas and beliefs that shape the patient's behavior.

The management and control of posttraumatic symptoms is also a priority of Phase 1 treatment. For example, if the patient has a spontaneous flashback or episode of intrusive recall of trauma during treatment, the therapist helps to teach skills to modulate the intensity of the experience. In this phase of treatment, the clinician would assist the patient to develop control of posttraumatic and dissociative symptomatology and to modulate psychophysiological arousal levels rather than encourage further exploration of the intrusive traumatic material.

Skills training is often an essential component of the safety and stabilization phase of DID treatment. These interventions address mental processes and deficiencies that undermine safety; they include enhancing emotional

awareness and emotional regulation, decreasing affect phobia, building distress tolerance, and learning to optimize effectiveness in relationships. Several relevant skills training programs have been described in the literature, among them Systems Training for Emotional Predictability and Problem Solving (Blum, Pfohl, St. John, & Black, 2002), Trauma Adaptive Recovery Group Education and Therapy (Ford & Russo, 2006), acceptance and commitment therapy (Follette & Pistorello, 2007), and Seeking Safety (Najavits, 2001). Dialectical behavior therapy (DBT; Linehan, 1993a, 1993b) has strong empirical support for the treatment of borderline personality disorder (Salsman & Linehan, 2006) and complex trauma (Wagner, Shireen, Rizvi, & Harned, 2007). Adaptations of DBT to Phase 1 of the treatment of DID are currently being developed in several countries (e.g., Somer, Rivera, & Berger, 2010; Van Orden, Schultz, & Foote, 2009). DBT elements, among others, have been incorporated into the first training manual specifically developed for dissociative disorders (Boon, Steele, & Van der Hart, 2010).

Working with alternate identities. In general, clinicians treating DID find it helpful to bring therapeutic attention to the alternate identity *system* as an organized, subjectively "logical," rule-bound set of interacting and/or conflicting states rather than to focus attention solely on the discrete alternate identities. In learning about the nature of the disorder and their internal systems, DID patients must begin to understand, accept, and access the alternate identities that play an active role in their current lives. The patient's accountability for the conduct of all alternate identities—in the external world, in therapy, and internally—is usually discussed early in treatment. Strategies designed to improve internal communication may include techniques to encourage negotiation between the alternate identities, acknowledgement of the importance of all alternate identities, and the establishment of commitments by all identities for safety from self-harm and/or suicidal behaviors.

The development of internal cooperation and co-consciousness between identities is an essential part of Phase 1 that continues into Phase 2. This goal is facilitated by a consistent approach of helping DID patients to respect the adaptive role and validity of all identities, to find ways to take into account the wishes and needs of all identities in making decisions and pursuing life activities, and to enhance *internal* support between identities. Early in the treatment process, some alternate identities deny or disavow past traumatic experiences and/or their associated affects. It is an important part of the therapy for these identities to progressively accept their disavowed memories and feelings, hence accepting the role and importance of the other identities that hold them. The therapist can facilitate the process of acceptance by helping the alternate identities to make internal agreements (e.g., "If you are able to acknowledge and accept some of the feelings that your 'angry part' experiences, perhaps that part can agree to stop some of the destructive behaviors that threaten your safety").

Clinicians must accept that successful treatment of DID almost always requires interacting and communicating in some way with the alternate identities. Ignoring alternate identities or reflexively telling identities to "go back inside" is frankly countertherapeutic. Early in the treatment, therapists and patients must establish safe and controlled ways of working with the alternate identities that will eventually lead to co-consciousness, co-acceptance, and greater integration. In order to work with alternate identities, clinicians can access them directly or indirectly. Identities can be accessed directly (e.g., "I need to talk to the parts of you who went to Atlantic City last night and had unsafe sex"). Experienced clinicians also develop a repertoire of skills to access alternate identities more indirectly. For example, the patient can be asked to "listen inside" to hear what the other identities have to say, or the clinician may suggest that the identities engage in inner conversations with one another to communicate information or negotiate important issues. The therapist may insist that "all parts who need to know should listen" when crucial matters are being discussed, or he or she can "talk through" to communicate with alternate identities relevant to the current clinical issues. References by Putnam (1989), Ross (1997), R. P. Kluft (2001, 2006), R. P. Kluft and Fine (1993), and Van der Hart et al. (2006) contain more extensive discussions of treatment strategies for accessing and working with alternate identities.

Trance logic characterizes the thinking of DID patients. For example, some alternate identities may insist that they do not inhabit the same body as the others or that suicide or self-injury would have no effect on them; they may even be invested in killing off the "others." Serious safety problems can result from this issue, and it is important to directly challenge this extreme form of dissociative denial, sometimes called *delusional separateness*. In some cases, however, it may take many sessions to erode this delusion of separateness, because this belief may hold back painful, powerful cognitions, affects, conflicts, and memory material.

Some authors have suggested that it is helpful to generate an ongoing "map" or "roster" of the patient's current view of the alternate identity system (R. P. Kluft, 1993a; Putnam, 1989; Ross, 1997). In doing so, clinicians should *not* try to identify or elicit identities solely for the sake of mapping. It can be potentially destabilizing and countertherapeutic to ask patients to reveal alternate identities before they are psychologically prepared to do so. In general, work with alternate identities should occur as they appear naturally in relation to current clinical issues. However, in situations involving significant safety problems, in times of repeated acting out by the patient, and/or at times of therapeutic impasse, it can be essential to directly elicit or make contact with alternate identities, previously known or not, that are related to these difficulties.

Trust and the therapeutic alliance. Clinicians should never underestimate the difficulties that DID patients have with establishing and

maintaining a therapeutic alliance. Patients with extensive childhood histories of traumatic experiences often have major difficulties with trust related to maltreatment and/or neglect by family members, caregivers, and others in positions of authority. This mistrust frequently manifests itself in the therapeutic relationship and can play out in complex and shifting transference manifestations (D. Brown et al., 1998; Davies & Frawley, 1994; R. P. Kluft, 1994; Loewenstein, 1993; Pearlman & Saakvitne, 1995). Such "traumatic transference" reactivity may be enacted in overt and covert ways (e.g., one identity appears to trust the therapist, whereas others feel vulnerable and mistrustful and work to sabotage the therapy). Finally, patients with a history of child abuse—especially incest—may be at particular risk of sexual exploitation by authority figures, including mental health professionals (R. P. Kluft, 1990). DID patients with a history of therapist abuse usually require an even longer time to develop a sense of safety in treatment, let alone approaching trust.

Effective therapy for DID requires a therapist who is actively engaged in both the treatment process and treatment interactions. It is helpful for the therapist to structure sessions to include education about the nature of DID and trauma treatment and about the intense discomfort that can be engendered during treatment. It is also helpful for the therapist to anticipate and openly discuss traumatic transference issues, particularly negative transferences. A gradual fostering of a real therapeutic alliance with the DID patient will occur as the clinician helps the patient to pace the therapeutic work, learn skills for mastering symptoms and crises, separate the traumatic past from the present, and change PTSD and DID-based cognitive distortions.

DID patients vary widely in ego strength, commitment to treatment, social supports, life stresses, economic resources, and other factors that may make them more or less able to undertake a demanding, change-oriented treatment. Accordingly, some patients may continue in Phase 1 treatment for long periods of time—sometimes even for the entire course of treatment. These patients may make considerable improvements in safety and overall functioning but may not be able to participate in an extensive, emotionally intense, detailed exploration of their trauma history. In the case of chronically low-functioning patients, the focus of treatment should consistently be stabilization, crisis management, and symptom reduction (*not* the processing of traumatic memories or the fusion of alternate identities). Several factors may influence a decision to keep the focus on the Phase 1 goals of stabilization and symptom reduction. These include severe attachment problems, minimal ego strength and coping capacity, ongoing enmeshment with perpetrators, severe *DSM–IV–TR* Axis II pathology, significant medical problems, age, and ongoing substance abuse and other addictions, among others (see Boon, 1997; R. P. Kluft, 1997; R. P. Kluft & Loewenstein, 2007).

Phase 2: Confronting, Working Through, and Integrating Traumatic Memories

In this phase of treatment, the focus turns to working with the DID patient's memories of traumatic experiences. Effective work in this phase involves remembering, tolerating, processing, and integrating overwhelming past events. This work includes the process of *abreaction*—the release of strong emotions in connection with an experience or perception (usually a past experience or perceptions of a past experience)—which has a long and venerable history in the mental health sciences. A body of clinical experience has demonstrated that abreactions, both spontaneous and those facilitated by psychotherapy, have helped many patients make major symptomatic and overall improvements.

It is optimal to carefully plan out and schedule work on traumatic memories. Patient and therapist should discuss and reach agreement upon which memories will be the focus, at what level of intensity they will be processed, which types of interventions may be used (i.e., exposure, planned abreactions, etc.), which alternate identities will participate, what steps will be taken to maintain safety during the work, and which procedures will be used to contain traumatic memories if the work becomes too intense. Patients benefit when therapists help them use planning and exploratory and titration strategies (see Fine, 1991; R. P. Kluft, 2001; R. P. Kluft & Loewenstein, 2007; Van der Hart et al., 2006) to develop a sense of control over the emergence of traumatic material. Specific interventions for DID patients in Phase 2 treatment involve working with alternate identities that experience themselves as holding the traumatic memories. These interventions help broaden the patient's range of emotions across alternate identities and assist the patient as a whole with tolerating the affects associated with the trauma, such as shame, horror, terror, rage, helplessness, confusion, anger, and grief.

Clinicians should provide education about the nature of the Phase 2 process, including the likelihood for symptom exacerbations during it, as well as the positive outcomes that can occur with successful memory processing (R. P. Kluft & Loewenstein, 2007). It may be helpful to discuss issues concerning the nature of "recovered" memory and the reconstructive aspect of autobiographical memory, among others (see "Informed Consent" and "Validity of Patients' Memories of Child Abuse").

In this phase, as the various elements of a traumatic memory emerge, they are generally explored rather than redissociated or rapidly contained—assuming that there is adequate time in sessions and that the patient can do this work without significant life disruptions. At times, however, it may be safest to encourage permissive amnesia between sessions. Over time, and often with repeated iterations, the material in these memories is transformed from traumatic memory into what is generally termed *narrative memory* (see D. Brown et al., 1998, for a comprehensive review of trauma and memory

in treatment). Modern approaches to abreaction involve cognitive change and mastery in addition to the intensive discharge of emotions and tensions related to the trauma; intense emotional discharge for its own sake may simply retraumatize and is contraindicated. A major mechanism of change is one of repeatedly re-accessing and re-associating and thus integrating fragmented and dissociated elements of traumatic memories into a comprehensible and coherent narrative (Van der Hart & Brown, 1992). A detailed discussion of the processes involved in working through traumatic memories is beyond the scope of the *Guidelines*, but they include cognitive reframing of the traumatic experiences and countering irrational guilt and shame through recognizing the adaptive responses that the patient had during those experiences.

Integrating traumatic memories refers to bringing together aspects of traumatic experience that have been previously dissociated from one another: memories and the sequence of the events, the associated affects, and the physiological and somatic representations of the experience. Integration also means that the patient achieves an adult cognitive awareness and understanding of his or her role and that of others in the events (Braun, 1988; D. Brown et al., 1998; Chu, 1998). Work on loss, grief, and mourning may be profound in this stage as the patient grapples with the realization of the many losses that the traumatic past has caused (some of which might continue in the present).

The process of Phase 2 work allows the patient to realize that the traumatic experiences belong to the past, to understand their impact in his or her life, and to develop a more complete and coherent personal history and sense of self. In addition, DID patients become able to recall the traumatic experiences across alternate identities, especially those who were previously amnestic or without emotional response to them. Some authors have used the term *synthesis* for this process (Van der Hart, Steele, Boon, & Brown, 1993; Van der Hart et al., 2006). Synthesis, as a basic level of integration, can be described as a controlled and paced therapeutic process that assists alternate identities who experience themselves as "holding" traumatic memories to share these with other identities who are unaware of this material or do not regard it as part of their autobiographical memory. Successful synthesis needs to be followed by a process of "realization" and "personification" (Van der Hart et al., 2006), that is, a full awareness that one has experienced the trauma but that this trauma is indeed in the past. Thus, the patient gives the traumatizing event a place in his or her personal autobiography. Sometimes it is the realization process that the DID patient fears most, resulting in him or her avoiding the synthesis of traumatic memories at all costs.

Even in this stage of treatment, intensive memory work should not be allowed to dominate session after session. Patients can be retraumatized and/or destabilized if the treatment does not allow for adequate time to deal with the impact of the trauma or if it fails to allow periods of time for the

patient to pause and regroup as well as to focus on everyday functioning and living. Even with careful therapeutic planning, destabilization can and may require that the therapy return to Phase 1 issues such as safety management, stabilization, internal communication, containment, and symptom management. The therapist may need to address any resistance and/or reluctance among alternate identities to integrating traumatic memories. Trauma-based cognitive distortions and/or transference reactivity also may interfere with Phase 2 work, requiring systematic attention to these. Slowing the pace or discontinuing the focus on the traumatic memories may be necessary if a patient maintains a stance of refusal, repeatedly produces "new" memories rather than focuses on the synthesis of material already at hand, and/or becomes repeatedly destabilized during Stage 2 work, among others.

As traumatic experiences are integrated, the alternate identities may experience themselves as less and less separate and distinct. Spontaneous and/or facilitated fusions among alternate identities may occur as well. Facilitated fusions often involve "fusion rituals." These therapeutic ceremonies usually involve imagery or hypnosis and "are perceived by some . . . patients as crucial rites of passage from the subjective sense of dividedness to the subjective sense of unity" (Kluft, as quoted in R. P. Kluft, 1993a, p. 119). The patient's experience is that alternate identities join together with an image of joining together or becoming unified. "[These rituals] merely formalize the subjective experience of the work that therapy has already accomplished" (R. P. Kluft, 1993a, p. 120).

Fusion rituals are useful when, as a result of psychotherapeutic work, separateness no longer serves any meaningful function for the patient's intrapsychic and environmental adaptation. At this point, if the patient is no longer narcissistically invested in maintaining the particular separateness, fusion is ready to occur. However, clinicians should *not* attempt to press for fusion before the patient is clinically ready for this. Premature attempts at fusion may cause significant distress for the DID patient or, alternatively, a superficial compliance wherein the alternate identities in question attempt to please the therapist by seeming to disappear. Premature fusion attempts can also occur when the therapist and patient collude to avoid particularly difficult therapy material.

Phase 3: Integration and Rehabilitation

In Phase 3 of DID treatment, patients make additional gains in internal cooperation, coordinated functioning, and integration. They usually begin to achieve a more solid and stable sense of self and sense of how they relate to others and to the outside world. In this phase, DID patients may continue to fuse alternate identities and improve their functioning. They may also need to revisit their trauma history from a more unified perspective. As patients become less fragmented, they usually develop a greater

sense of calm, resilience, and internal peace. They may acquire a more coherent sense of their past history and deal more effectively with current problems. The patient may begin to focus less on the past traumas, directing energy to living better in the present and to developing a new future perspective. With a greater level of integration, the patient may be more able to review traumatic "memories" and decide that some are more symbolic—that they seemed "real" at the time but did not occur in objective reality.

Many tasks of late-phase treatment of DID are similar to those in the treatment of nontraumatized patients who function well but experience emotional, social, or vocational problems. In addition, the more unified DID patient may need specific coaching about dealing with everyday life problems in a nondissociative manner. Similarly, the patient may need help in tolerating everyday stresses, petty emotions, and disappointments as a routine part of human existence. Eventually, many patients experience this treatment phase as one in which they become increasingly able to realize their full potential in terms of personal and interpersonal functioning.

TREATMENT MODALITIES

Framework for Outpatient Treatment

The primary treatment modality for DID is individual outpatient psychotherapy. The frequency of sessions and duration of treatment may depend on a number of variables, including the patient's characteristics, the abilities and preferences of the clinician, and external factors such as insurance and other financial resources and the availability of skilled therapists. DID patients vary widely in their motivation, resources for treatment, and comorbidities, all of which affect the course of treatment. As with treatment for other patients with complex posttraumatic disorders, treatment for DID patients is generally long term, usually requiring years, not weeks or months.

The frequency of sessions may vary depending on the goals of the treatment and the patient's functional status and stability. The minimum frequency of sessions for most DID patients is once a week, with many experts in the field recommending twice or even three times a week if resources permit this. For high-functioning patients, once a week is often enough, although the need to balance maintaining the patient's functioning with working on difficult material may require more frequent appointments. For those whose symptoms are florid and whose lives are chaotic, once per week is likely to be insufficient. In certain circumstances, a greater frequency of sessions (up to three or more per week) can be scheduled on a time-limited basis to enable the chaotic patient to sustain adaptive functioning and/or (as an alternative to hospitalization) to contain self-destructive and/or severely dysfunctional behavior. Frequent outpatient sessions for

restabilization should generally be limited to brief periods to minimize regression and overdependence on the therapist.

Although the 45- to 50-min session remains the norm for most therapists, many therapists have found extended sessions (e.g., 75–90 min) to be useful (e.g., for preplanned work on traumatic memories). Therapists must attempt to help patients reorient themselves to the external reality well before the scheduled end of each session so patients do not leave sessions in a decompensated or dissociated state. The therapist can develop interventions with the patient for the purposes of becoming grounded in the present and ending the session (e.g., alerting the patient some minutes before the end of the session to initiate the process of reorientation).

There is a divergence of opinion concerning very lengthy sessions (e.g., sessions longer than 90 min), with some experienced clinicians doubting if they are ever required and others finding them useful for specific purposes. If used, they should be scheduled, be structured, and have a specific focus, such as completing integration of traumatic memories. Very lengthy sessions may also be indicated when logistics force the patient to come to the therapist infrequently but to work intensely while there.

Types of treatment for DID. The most commonly recommended treatment orientation is individual psychodynamically oriented psychotherapy, which often eclectically incorporates other techniques (Putnam & Loewenstein, 1993). For example, cognitive-behavioral therapy techniques can be modified to help patients explore and change dysfunctional trauma-based beliefs or cognitions or manage stressful experiences or impulsive behavior. Many therapists use hypnosis as an adjunctive modality of DID (Putnam & Loewenstein, 1993; see below). The most common uses of hypnosis are for calming, soothing, containment, and ego strengthening. In addition to individual psychotherapy, patients may benefit from specialized interventions such as family or expressive therapy, DBT (Linehan, 1993a, 1993b), eye-movement desensitization and reprocessing (EMDR; Shapiro, 2001), sensorimotor psychotherapy (Ogden et al., 2006), and other adjunctive treatments. Some patients additionally require specialized substance abuse or eating disorder treatment.

Learning theory and behavior therapy principles can guide the treatment of dissociative disorders to some degree. Learning theory is useful in understanding posttraumatic reactions such as conditioned fear, anger, and shame in response to external and internal cues that foster dissociation. Exploring and integrating traumatic memories can be conceptualized as a form of exposure therapy that enables the patient to transform traumatic memories. Overcoming phobic reactions also requires exposure (e.g., experiencing previously avoided bodily and emotional feelings; attaching to other individuals, including the therapist; and cooperating between alternate identities). It is counterproductive in most cases to use behavior modification techniques to punish the expression of dissociation itself

(e.g., to ignore or attempt to extinguish the expression of the alternate identities). Furthermore, aversive conditioning or extinction procedures are generally contraindicated because these may evoke previous abuse experiences.

Many specific techniques and interventions have been developed to facilitate DID treatment. These include imagery and hypnotic techniques, approaches to transference and countertransference, cognitive techniques, and so on. Much of the literature on therapy for complex traumatic stress disorders may be helpful as well (see, among others, Briere, 1989; Chu, 1988, 1998; Courtois, 1999, 2004; Courtois et al., 2009; Gold, 2000; Herman, 1992b; Ross, 2007), as may be the literature on the treatment of DID (see, among others, Fraser, 2003; R. P. Kluft, 1993a, 1993b, 1999; R. P. Kluft & Fine, 1993; Putnam, 1989; Rivera, 1996; Ross, 1997; Steele et al., 2005; Van der Hart et al., 1998, 2006; Watkins & Watkins, 1988).

Treatment for DID is typically provided by an individual psychotherapist. However, additional clinicians may be helpful in making up a treatment team. Depending on individual circumstances, treatment teams may include representatives from a variety of professional disciplines, including psychopharmacologists, case managers, family therapists, expressive therapists, sensorimotor psychotherapists, and medical professionals. It is vital that members of the treatment team coordinate their treatment of the DID patient and that there be clarity about which clinician is responsible for overall treatment management and decision making. Because of DID patients' divided mental processes and amnesia, it is easy for them to develop relationships in which one set of alternate identities interacts with one clinician and another set with another clinician, even without confusion of treatment team roles. This can thwart the goals of more integrated functioning and tends to externalize patients' internal conflicts to different members of the treatment team.

Inpatient Treatment

Treatment of DID typically occurs on an outpatient basis, even during the processing of traumatic material. However, inpatient treatment may be necessary at times when patients are at risk for harming themselves or others and/or when their posttraumatic or dissociative symptomatology is overwhelming or out of control. Inpatient treatment should occur as part of a goal-oriented strategy designed to restore patients' functioning so that they are able to resume outpatient treatment expeditiously. Efforts should be made to identify the factors that have destabilized or threaten to destabilize the DID patient, such as family conflicts, significant losses, and so on, and to determine what must be done to ameliorate these. Inpatient treatment is often used for crisis stabilization and the building (or restoring) of skills and coping strategies.

At times, hospitalization may provide an opportunity for diagnostic clarification. An inpatient evaluation can screen for the presence of other comorbid conditions that require immediate treatment (e.g., a major depressive episode that manifests with increased PTSD symptoms, or a subtle or emerging schizophrenic disorder with superimposed dissociative symptomatology). Conversely, the diagnosis of DID itself may require the kind of intensive, sequential observation and diagnostic efforts that a hospital can provide, or there may be some other persistent syndrome masking DID (e.g., conversion disorder, obsessive-compulsive disorder, eating disorder, substance abuse, or apparent borderline personality disorder).

Given the current constraints of third-party payers, most hospitalizations are brief and only for the purpose of safety, crisis management, and stabilization. In some cases, the structure and safety of a hospital setting can facilitate therapeutic work that would be destabilizing or even impossible in an outpatient setting. When resources are available to support a more prolonged length of stay, inpatient treatment can include planned and judicious work on traumatic memories and/or work with aggressive and self-destructive alternate identities and their behaviors.

Specialized inpatient units dedicated to the treatment of trauma and/or dissociative disorders may be particularly effective in helping patients develop the skills they need to become more safe and stabilized. These programs provide services that are not usually provided in general hospital psychiatric programs: specialized diagnostic assessments, intensive individual psychotherapy, specialized group therapies, expert psychopharmacological interventions, and specialized trauma-focused work on symptom management and skill building.

During inpatient treatment, seclusion and physical or chemical restraints may be required for the DID patient who is behaving violently toward himself or herself or others and who has not responded to verbal, behavioral, or pharmacological interventions. Unfortunately, restraint and seclusion may be traumatizing to all patients, let alone those with preexisting posttraumatic psychopathologies. Accordingly, many hospital systems are now committed to an ideal goal of minimizing or eliminating the use of seclusion and restraint. In this regard, these restrictive measures often can be avoided by careful planning in advance for symptom management and containment strategies to help in times of crisis. Some hospital systems require that all patients develop "personal safety plans" that enumerate factors that tend to ameliorate or reduce the their ability to maintain their safety. For DID patients, these may include listing idiosyncratic posttraumatic triggers as well as measures that provide soothing and comfort. Specific interventions for DID patients might include accessing helper alternate identities, using imagery to find an inner "safe place" for overwhelmed or self-destructive alternate identities, and using imagery to "dial down" or otherwise attenuate strong affects. Medications for anxiety and/or agitation such

as benzodiazepines or neuroleptics may also help to reduce agitation and avoid a crisis.

The use of "voluntary" physical restraints to control a violent alternate identity while working through trauma is no longer considered an appropriate intervention.

Partial Hospital or Residential Treatment

DID patients may be able to gain some assistance from generic partial hospital programs as a step down from inpatient treatment. Programs that allow an individualized focus for the trauma survivor and that are cognizant of trauma-related issues may be most helpful for this purpose.

Specialized partial hospital or residential treatment for DID patients and others with severe trauma can be very helpful as either a step down from inpatient care or as a more intensive outpatient modality to prevent inpatient hospitalization and/or to provide intensive skills training. In general, these specialized programs use multiple daily groups to educate about trauma-related disorders, to teach symptom management skills, and to provide training in relationships and other life skills. DBT or other more formal, structured techniques for symptom management may be incorporated into these programs. Unfortunately, few of these specialized programs are in operation at this time.

Group Therapy

Patients with DID generally do poorly in generic therapy groups that include individuals with heterogeneous diagnoses and clinical problems. Many DID patients have difficulty tolerating the strong affects elicited by traditional process-oriented psychotherapy groups or those that encourage discussion, even in a limited way, of participants' traumatic experiences. Some such therapy groups have resulted in symptom exacerbation and/or dysfunctional relationships among group members.

Group psychotherapy is not a viable *primary* treatment modality for DID. However, certain types of time-limited groups for selected patients with DID or complex PTSD can be valuable adjuncts to individual psychotherapy. These types of groups can help educate patients about trauma and dissociation, assist in the development of specific skill sets (e.g., coping strategies, social skills, and symptom management), and help patients understand that they are not alone in coping with dissociative symptoms and traumatic memories. These task-oriented groups should be time limited, highly structured, and clearly focused.

Some clinicians have reported that carefully selected DID patients may benefit from longer term, homogenous, more process-oriented groups for DID and complex PTSD patients. These groups provide ongoing support,

focus on improvement of interpersonal functioning, and buttress the goals of individual therapy. Successful groups of this type require an explicit treatment frame with set expectations and boundaries for the participants' actions inside and outside the group (e.g., limitations on discussion of trauma memories in group, no socializing between members outside the group).

Some patients may make good use of 12-step groups such as Alcoholics Anonymous, Narcotics Anonymous, or Al-Anon when addressing substance abuse problems. However, 12-step "incest survivor" groups or nonprofessionally led "self-help" groups are generally viewed as contraindicated for DID patients, as their typical format is unregulated and may result in emotional flooding and other psychological distress. In addition, there is the potential for poor boundaries among group members, including disturbed, overdependent, and/or exploitive behavior. Many experienced therapists will not treat DID patients who insist on participating in these types of groups.

Pharmacotherapy

Psychotropic medication is not a primary treatment for dissociative processes, and specific recommendations for pharmacotherapy for most dissociative symptoms await systematic research. However, therapists report that most DID patients have received medication as one element of their treatment (Putnam & Loewenstein, 1993). In the only naturalistic study of outpatient dissociative disorder treatment, 80% of patients received adjunctive medication (Brand, Classen, Lanius, et al., 2009). Pharmacotherapy for dissociative disorder patients typically targets the hyperarousal and intrusive symptoms of PTSD, and comorbid conditions such as affective disorders and obsessive-compulsive symptoms, among others (Loewenstein, 1991b; Torem, 1996). Informed consent concerning medication protocols for DID should include an understanding that prescribing is mostly empirical in nature.

Psychopharmacologic management of DID requires careful attention to boundaries and active lines of communication between treating therapists, nonpsychiatric treatment team members, and the medicating psychiatrist to avoid "splitting" the treatment team (especially when the psychiatrist is not also the primary therapist). It is essential that the functions of the therapist and the medicating psychiatrist be clearly defined. The patient should have only one clinician involved in intensive psychotherapy. In general, the medicating physician should play an adjunctive role, focusing primarily on medication management and seeing the patient more frequently only when medications are being adjusted or in response to a psychiatric emergency. The primary therapist should be responsible for all psychotherapy emergencies. The psychiatrist should neither be considered the default backup when the patient is unable to reach the therapist

nor provide routine psychotherapy coverage during the therapist's absence for vacation or for other reasons unless there have been specific negotiations concerning a change in roles. The regular exchange of significant information between treatment team members is important to provide an ongoing context for interventions and adjustments to the treatment. As in any psychopharmacologic treatment, issues of non-adherence to the medication regimen, including overuse, underuse, and/or surreptitious use of other drugs or alcohol, should always be a consideration. Investigation of suspected non-adherence may require a working knowledge of DID psychotherapy techniques and engagement with the DID alternate identity system for full elucidation. This task may fall to the primary therapist if the psychopharmacologist is not familiar with such inquiries.

Alternate identities within the DID patient may report different responses to the same medication. This may be because of the different levels of physiologic activation in different identities, somatoform symptoms that can realistically mimic all known medication side effects, and/or the identities' subjective experience of separateness rather than because of any actual differential biological effects of the medications. In general, medications are likely to be effective only when the targeted symptoms are reported across "the whole human being." DID patients may have many day-to-day symptom fluctuations that are due to the modulation of dissociative defenses as well as their personal predicaments and life stresses. Thus, it is most helpful in changing or adjusting medications to attend to the overall "emotional climate" of the patient's presentation rather than trying to medicate the day-to-day psychological changes in "weather." Effective psychotherapeutic skills training in affect regulation, grounding, and management of PTSD and dissociative symptoms may be more effective than medication.

Specific alternate identities or groups of identities may experience themselves as "blocking" or overriding the effects of medication. This may occur in a variety of ways, including through increasing agitation through heightening internal conflict or persecution or increasing activation of the identities' baseline physiologic states. Similarly, identities may "trick" other identities by not taking medications or by taking more than the prescribed amount of medications, with other identities who wish to adhere to the medication regimen having amnesia for these behaviors. Also, because of the trance logic of separateness, some DID patients may take too many medications based on the belief that each alternate identity needs a dose of medication for a "separate body."

Medications for DID are usually best conceptualized as "shock absorbers" rather than as curative interventions. Partial responses to many different medications are common with DID and other complex posttraumatic disorder patients. Thus, prescribers should be especially alert to the potential negative effects of polypharmacy in this patient population. In times of crisis, the psychiatrist may choose to adjust doses of medications

for increased problems with sleep, anxiety, and/or increased PTSD symptoms, among others, either as standing or as "as needed" doses. Often this is a more parsimonious and helpful intervention than initiating new trials of medications.

Nearly all classes of psychotropic medications have been used empirically with DID patients. *Antidepressant medications* are most often used to treat depressive symptoms and/or PTSD symptoms. The standard response ranges for titration of selective serotonin reuptake inhibitor antidepressants apply to this population (e.g., to address symptoms of anxiety [using low doses], symptoms of depression [moderate doses], and obsessive-compulsive symptoms/refractory depression [higher doses]). Older antidepressant groups such as the monoamine oxidase inhibitors and the tricyclic antidepressants have largely been replaced by the selective serotonin reuptake inhibitors because of the latter's more favorable side effects and safety. However, these older medications may be helpful in some patients who can use them safely, especially the anti-obsessive tricyclic medication clomipramine (Anafranil). It is helpful to advise the patient about partial antidepressant responses. Often the best result is that the patient acknowledges that he or she would be *more* depressed without antidepressant medication rather than experiencing a significant remission in depressive symptoms.

Anxiolytics may be used primarily on a short-term basis to treat anxiety, but the clinician must keep in mind that the commonly used benzodiazepine medications have addictive potential, a risk for those patients vulnerable to substance abuse. Patients with PTSD may be tolerant to seemingly quite high doses of benzodiazepines. This is thought to be because of the severe chronic hyperarousal and putative alterations in benzodiazepine receptor binding in these patients. However, some DID patients can successfully be maintained on a stable long-term benzodiazepine regimen. In general, in this population longer acting benzodiazepines (e.g., lorazepam [Ativan], clonazepam [Klonopin]) are safer and have fewer problematic side effects than shorter acting benzodiazepines such as alprazolam (Xanax) and ultra-short-acting hypnotics.

Other medications with marked *sedative-hypnotic effects* may be used for sleep problems in this population (e.g., trazadone [Desyrel]; diphenhydramine [Benadryl]; mirtazapine [Remeron]; low-dose tricyclic antidepressants; and low-dose neuroleptics with fewer extrapyramidal effects, such as quetiapine [Seroquel] or chlorpromazine [Thorazine]). DID patients commonly suffer from a complex sleep disorder including PTSD nightmares and flashbacks, sleep problems related to affective disorders, triggered fear reactions at night because of recall of reported nocturnal abuse, and the nighttime activities of some alternate identities. Many of the latter are experienced as occurring only at night, and "daytime" identities may experience amnesia for their existence and activities.

Sleep problems in DID are usually best addressed in the overall framework of the treatment, using symptom management strategies for fearful alternate identities, negotiating sleep for nocturnal identities, and using trauma-focused cognitive behavioral strategies to decrease PTSD reactivity at night, along with the judicious use of medications. In general, barbiturates, chloral hydrate, and similar medications should be avoided in DID patients because of their addictive qualities and the potential for lethal overdose.

Neuroleptic or *antipsychotic medications*, particularly the newer atypical agents, have been used in relatively low doses with DID to successfully treat overactivation; thought disorganization; intrusive PTSD symptoms; as well as chronic anxiety, insomnia, and irritability. Care must be taken to not confuse psychotic auditory hallucinations with the complex, personified, (mostly) inner voices described by DID patients that represent communications between alternate identities (see Loewenstein, 1991a). Hallucinatory phenomena in DID, even when alternate identities engage in command hallucinations mandating danger to self or others, are usually unaffected by even high-dose neuroleptics. Instead, because of problematic side effects such as somnolence neuroleptics may lead to decreased function rather than to the disappearance of voices.

Multimodal dissociative hallucinosis with auditory, visual, olfactory, tactile, and gustatory manifestations, often in the context of loss of reality testing (dissociative psychosis), generally does not respond robustly to antipsychotic medication, although this may help with overall hyperarousal, panic, terror, and thought disorganization. This may permit effective psychotherapeutic interventions for the dissociative/posttraumatic processes underlying these symptoms. Individuals with DID who have true comorbid psychotic symptoms may be responsive to neuroleptic medication for symptoms of the psychosis even though the DID symptoms themselves remain relatively unaffected.

Neuroleptics have many side effects. Most notable is that some of the "atypical" second-generation antipsychotic agents are associated with an increased risk for significant weight gain and a metabolic syndrome including hypercholesterolemia and glucose intolerance, frequently leading to frank diabetes mellitus. Medications associated with these side effects include clozaril (Clozapine) and olanzapine (Zyprexa) and, to a lesser extent, quetiapine (Seroquel), risperidone (Risperdal), aripiprazole (Abilify), and ziprasadone (Geodon). The psychiatrist must carefully monitor all patients taking atypical antipsychotics, and, if significant weight gain and/or the metabolic syndrome develop, the patient and psychiatrist should carefully review the risks and benefits of continuing the medication.

Some severely and persistently ill DID patients who function primarily at the level of chronically psychotic patients have responded well to clozapine for severe PTSD symptoms and chronic thought disturbance. The latter may manifest with refractory, often bizarre, quasi-delusional or frankly delusional

cognitive distortions. These patients may display mistrust bordering on true paranoia.

Mood stabilizers are medications that specifically target mood swings in bipolar patients. Because many DID patients suffer from rapid changes in mood, psychiatrists frequently misdiagnose them with rapid-cycling or Type II bipolar disorder. However, a careful history usually shows that the mood swings are actually due to PTSD intrusions, affect dysregulation, and the switching and/or overlap/interference between alternate identities. Thus, only a small minority of DID patients with true comorbid bipolar disorder as manifested by clear-cut, sustained alternating manic/hypomanic and depressive episodes will report improved mood stability with these agents. There is no evidence that bipolar disorder is more (or less) common among DID patients than in the general population.

Other medications used to treat DID patients include naltrexone (Revia), an opiate antagonist that may have some efficacy in decreasing the pressure for self-mutilation or other self-destructive and self-stimulatory behaviors, especially if the patient reports a "high" from self-harm. Some patients have responded to centrally active beta blockers such as propranolol (Inderal) for PTSD hyperarousal and panic. Clonidine (Catapres) and prazosin (Minipress), are centrally acting alpha agonists primarily used as antihypertensive medications; clonidine may be effective for hyperarousal and intrusive PTSD symptoms in some DID patients. Well-conducted studies in combat veterans have shown that prazosin specifically targets PTSD nightmares (Raskind et al., 2003). Psychopharmacologists have also found prazosin helpful for this indication in some DID patients. However, an acute increase in nightmares due to life stresses, additional traumas, and/or work on difficult material in therapy is less likely to respond to this intervention and generally responds better to psychotherapeutic restabilization. The most problematic side effect of these medications is hypotension, especially in patients with baseline low blood pressure and/or patients with restrictive eating disorders.

Psychostimulants (methylphenidate [Ritalin and others], mixed amphetamine salts [Adderal and others], dextroamphetamine [Dexadrine and others], etc.) may be used for comorbid attention-deficit/hyperactivity disorder in DID patients. However, the differential diagnosis of dissociative attentional problems and attention deficit disorder (ADD) may be difficult, requiring careful attention to the context and nature of the apparent ADD symptoms. This may be particularly true in traumatized children and adolescents whose attentional and hyperactivity problems tend to be reactions to PTSD triggers, alternating with dissociative "spacing out," rather than the more typical pattern found in ADD/HD (hyperactivity disorder) children. ADD/HD and posttraumatic/dissociative disorders may coexist in the same patient, complicating differential diagnosis. Furthermore, stimulants may have a nonspecific positive effect on attention, even in patients

without ADD. Psychostimulants have the potential for abuse in all patients and may be particularly misused by DID patients because of the frequently co-occurring eating disorders found in this population.

Most experienced DID pharmacologists do not consider "fatigue" to be an indication for stimulant use in this population. A recent study found a history of childhood sexual abuse in a large percentage of a population of patients diagnosed with "chronic fatigue syndrome" (Heim et al., 2009). Dissociative somatoform symptoms and/or overuse of sedating medications because of polypharmacy may more commonly account for chronic fatigue in these patients.

Hospitalized DID patients experiencing acute anxiety, agitation, intrusive PTSD symptoms, chaotic switching, and/or urges to harm themselves or others may respond to as needed oral or intramuscular benzodiazepines (primarily lorazepam [Ativan]) and/or oral or intramuscular neuroleptics. Either typical or atypical neuroleptics may be given for this indication. Quetiapine (only available orally) may be used in moderate doses for subacute intervention in these patients. Typical neuroleptics used for acute agitation in inpatient DID patients include haloperidol (Haldol) and fluphenazine (Prolixin), but atypical neuroleptics such as intramuscular ziprasidone or intramuscular or sublingual olanzapine may also be useful for the rapid treatment of severe, acute agitation and/or dangerousness to self or others. In general, the repeated use of as needed medication predicts the need for regular dosing to preclude generating gaps in medication coverage and/or to clarify which symptoms are actually being treated.

Many DID patients use fewer medications as treatment progresses because of a reduction in the intensity of PTSD and other severe symptoms, especially as fusion/integration occurs. However, as the more integrated patient becomes less globally symptomatic, Axis I comorbidities, such as affective disorders, obsessive-compulsive disorder, ADD, and even psychotic disorders, may become more clearly apparent. Many DID patients may require maintenance medication for the treatment of mood disorders, obsessive-compulsive disorder, and so on, even after full fusion/integration.

Just like other patients, DID patients need careful discussion of the risks and benefits of the use of medications, the risks of discontinuing medications, and the need for adherence to medication regimes. As with all patients, changes in stable, helpful medications should be done carefully, optimally when the patient is not in crisis or doing intensive work in therapy and when the reemergence of symptoms would be least disruptive to everyday life. The patient, the medicating psychiatrist, and the primary therapist should all be involved in collaborating around questions of medication continuation/discontinuation, particularly when the patient is more stabilized in later stages of treatment.

Unfortunately, systematic research on medications for DID does not exist, and only a few studies of pharmacotherapy for PTSD have had a

participant pool of female survivors of chronic childhood maltreatment. Until a better research foundation is achieved, the pharmacological treatment for DID will remain almost entirely empirical and based on clinical experience.

Hypnosis as a Facilitator of Psychotherapy

Hypnosis has been used to assist in the treatment of dissociative disorders since the early 19th century (Ellenberger, 1970), and there is a wide literature concerning the use of hypnosis for DID treatment (see Cardeña, Maldonado, Van der Hart, & Spiegel, 2009; R. P. Kluft, 1982, 1988a, 1989, 1994; Phillips & Frederick, 1995; Ross & Norton, 1989a). Several powerful rationales support the use of hypnotic strategies as an adjunct to the treatment of DID. First, DID patients are more hypnotizable than other clinical populations (Frischholz, Lipman, Braun, & Sachs, 1992), and higher hypnotizability correlates with the likelihood of therapeutic success with hypnosis. Second, hypnotic work can potentiate various therapeutic strategies. Studies have demonstrated the clinical efficacy of hypnosis for treating posttraumatic symptomatology (Cardeña, Maldonado, et al., 2009), and hypnosis-facilitated interventions have played a major role in the successful treatment of large series of DID patients (R. P. Kluft, 1984, 1986, 1993a, 1994). Third, because hypnosis can take the form of spontaneous trance, autohypnosis, or heterohypnosis (trance induced by another person; H. Spiegel & Spiegel, 1978, 2004), some form of hypnosis inevitably takes place in therapeutic work with this highly hypnotizable group of patients. One formulation of this issue is that dissociative patients, usually unwittingly, use a variety of self-hypnotic strategies in an unbidden, uncontrolled, and disorganized way, and teaching them to exert some control over spontaneous hypnosis and self-hypnosis may allow them to contain certain distressing symptoms and to use their hypnotic talents to facilitate constructive self-care strategies.

Many techniques that rely upon the DID patient's autohypnotic skills—used with or without formal trance induction—have earned a place in DID treatment (R. P. Kluft, 1982, 1988a, 1989, 1994; Phillips & Frederick, 1995). These techniques include accessing alternate identities not immediately available, an intervention that can facilitate the emergence of identities critical to the therapeutic process and/or that can help resolve the situation of having a child-like, disoriented, or dysfunctional identity that is "stuck" at the end of the therapy session. Reconfiguration is a related technique in which a system of alternate identities in a dysfunctional disequilibrium can be "rearranged" by requesting that different identities assume important roles in a more safe and stable constellation.

Other hypnotherapeutic techniques have been designed to contain flashbacks and control the processing of abreactions and traumatic memories, to modulate affect, to explore and resolve distressing psychological

and somatoform symptoms, to place unsettled identities in settings away from the mental mainstream to protect function and safety, to put identities in a therapeutic "sleep" between sessions, to promote general restabilization, to encourage identities to communicate and to engage with one another constructively (e.g., Fraser's, 2003, dissociative table technique), and to promote or bring about integration (e.g., fusion rituals). For example, during Phase 2 (treating traumatic memories), hypnotic techniques such as internally visualizing memories on a controllable screen can help regulate and modulate the affect brought about by the memory. "Split screen" techniques can assist with the cognitive restructuring of traumatic events, and the judicious use of regression techniques (keeping in mind the vicissitudes of memory) may be helpful when recollecting past events. In Phase 3 (reintegration and rehabilitation), hypnotic techniques may assist in consolidating an adaptive sense of the self in the present and the future through, for example, rehearsing possible future events in a way so as to prevent relapse (Cardeña, Maldonado, et al., 2009).

DID patients' autohypnotic abilities allow many hypnotic techniques to be used effectively throughout DID treatment without formal trance induction. Patients can be taught to use at least some of these techniques outside of the therapist's office. In Phase 1 treatment, autohypnotic techniques may be especially helpful to induce relaxation, to allow the patient to use an imaginary safe place for self-soothing, to alleviate various symptoms, to help with dysphoric moods through the use of ego-strengthening suggestions, to provide better coping skills, to create skill in "grounding" into the present through the use of active-alert hypnosis, and so on. During subsequent phases, additional autohypnotic skills may be taught, such as containing traumatic memories and using an internally visualized location as a "meeting place" to permit identities to discuss issues and day-to-day concerns and to problem solve.

Clinicians should be aware of current controversies concerning the use of hypnosis in trauma treatment, particularly the use of hypnosis-facilitated techniques to explore areas of amnesia or to further explore fragmentary images or recollections (D. Brown et al., 1998). Authorities who support the use of hypnosis for these indications point to the recovery of material that has been confirmed at a later date (R. P. Kluft, 1995) and to the therapeutic progress that is often achieved through hypnotic techniques. Detractors argue that hypnosis-facilitated memory work will increase the patient's chances of mislabeling fantasy as real memory. However, it is likely that the untoward clinical outcomes attributed to hypnosis reside more in misleading cues and other misuses of hypnosis than in the modality of hypnosis itself. Evidence suggests that suggestive interventions such as misleading questions, rather than the use of hypnosis itself, produce memory distortions (Scoboria, Mazzoni, & Kirsch, 2006), especially in highly hypnotizable populations (McConkey, 1992). Like other interventions, hypnotherapy

should be used only with adequate training both in the modality itself and in its specific use with traumatized and dissociative patients.

In addition to being highly hypnotizable, some DID patients have been thought to be highly fantasy prone (Lynn, Rhue, & Green, 1988). A minority may be so, although several studies suggest that most DID patients are only moderately fantasy prone (Williams, Loewenstein, & Gleaves, 2004). Nonetheless, there is concern that at least some DID patients are vulnerable to confusing fantasy with authentic memory and/or mistaking experiences within the inner worlds of the personalities for events in external reality whether or not hypnosis is induced (R. P. Kluft, 1998). Thus, therapists who use hypnosis in an exploratory manner should minimize their use of leading questions and avoid hints and pressures that may potentially distort the details of what is recalled in hypnosis. Hypnosis may also leave patients with an unwarranted level of confidence in what has been recalled in hypnotic states, although there is evidence that specific informed consent concerning this latter issue may reduce such undue confidence (see Cardeña, Maldonado, et al., 2009).

Therapists who introduce the use of hypnosis or any other specialized technique should obtain appropriate informed consent from the patient concerning the possible benefits, risks, limitations, and current controversies concerning the technique in question. Informed consent should also include possible limitations on the permissibility of testimony in legal settings concerning recollections obtained under hypnosis based on the statutes and judicial rulings of the jurisdiction in which the therapist practices (American Society of Clinical Hypnosis, 1994).

EMDR

EMDR was developed in 1989 and became known for facilitating the rapid resolution of traumatic memories in uncomplicated PTSD (Shapiro, 1989), among other uses. However, early use of standard EMDR for patients with unrecognized DID resulted in serious clinical problems, including unintended breaches of dissociative barriers, flooding, abrupt emergence of undiagnosed alternate identities, and rapid destabilization (Lazrove & Fine, 1996; Paulsen, 1995; Shapiro, 1995; Young, 1994). As a result, clinicians are now strongly urged to assess all clients for the presence and extent of dissociation before introducing EMDR procedures regardless of the presenting problem. In addition, current expert consensus is that the original EMDR protocols must be modified for safe and effective use with DID patients (Beere, 2009; Fine, 2009; Forgash & Knipe, 2008; Gelinas, 2003; Paulsen, 2008; Twombly, 2005; Van der Hart et al., 2006).

EMDR has many potential benefits in the treatment of DID. These include a coherent manualized set of interventions for changing trauma-based distortions in self-representation, increasing associative linkages to

adaptive material, and facilitating the integration of processed traumatic material into alternate identities (Fine, 2009; Gelinas, 2003; Twombly, 2005). EMDR also enhances the development of new behaviors by enabling individuals to process past traumatic experiences and their current triggers and then develop new templates of desired abilities or behaviors.

Recommended Guidelines: A General Guide to EMDR's Use in the Dissociative Disorders (authored by the EMDR Dissociative Disorders Task Force and published in Shapiro, 1995, 2001) contains a number of recommendations. The Guide recommends that EMDR be used within an overall treatment approach rather than as a standalone treatment. If a dissociative disorder is present, only clinicians knowledgeable in the treatment of dissociative disorders should use EMDR procedures, and they should do so only after patient readiness for EMDR processing of traumatic material has been assessed. EMDR processing is recommended only when the patient is generally stable and has adequate coping skills, enough internal cooperation among alternate identities, and the ability to maintain the dual focus of awareness that is necessary in EMDR procedures (Forgash & Knipe, 2008; Gelinas, 2003; Lazrove & Fine, 1996; Paulsen, 1995; Twombly, 2005). Ongoing abusive relationship(s); strong opposition from alternate identities to processing; and serious comorbid diagnoses such as psychosis, active substance abuse, or severe character pathology are contraindications to the use of EMDR.

Modified EMDR can be helpful as an adjunctive technique in the treatment of DID. Paulsen (1995), Lazrove and Fine (1996), and Twombly (2000) introduced concepts of how EMDR could be used in treating dissociative disorders. Fine and Berkowitz (2001) presented an innovative phase-oriented model that uses the DID patient's high hypnotizability to alternate hypnotherapeutic and modified EMDR techniques. This allows traumatic material to be safely processed and integrated, as the patient is repeatedly restabilized. Modified EMDR procedures imbedded into the overall phase-oriented framework can be used when and where appropriate to do work on specific traumatic material, with the potential for reducing the risks of premature exposure to, and overactivation of, traumatic memories (Fine & Berkowitz, 2001; Forgash & Knipe, 2008; Gelinas, 2003; Paulsen, 2008; Twombly, 2005). The EMDR Institute Training Manual (Shapiro, 2009) now includes various EMDR interventions in the three phases of the phase-oriented approach.

Clinicians have adopted EMDR interventions for symptom reduction and containment, ego strengthening, work with alternate identities, and, when appropriate, the negotiation of consent and preparation of alternate identities for modified EMDR processing of traumatic memories. The various interventions include working with alternate identities and problem solving during processing (Fine & Berkowitz, 2001; Forgash & Knipe, 2008; Gelinas, 2003, 2009; Paulsen, 2008, 2009; Twombly & Schwartz, 2008); using Korn

and Leeds's (2002) Resource Development and Installation (Gelinas, 2003); using protocols to restore present-day orientation and safety (Knipe, 2009; Twombly, 2009a, 2009b); integrating hypnotic techniques into EMDR protocols to maintain stabilization (Fine & Berkowitz, 2001; Twombly, 2000, 2005); and using EMDR for "safe place" work, developing tolerance for affect and sensation, and developing internal cooperation among alternate identities. The coping skills acquired with these interventions are initially used to help with stabilization but eventually also help manage the processing of particularly frightening traumatic memories (Fine & Berkowitz, 2001; Paulsen, 1995; Twombly, 2005).

It is essential to reduce the risks of breaching dissociative barriers and flooding when using EMDR with DID patients. As noted by Van der Hart et al. (2006), "The risk inherent with the use of EMDR with chronically traumatized individuals is that it often reactivates too much traumatic memory too quickly" (p. 327). Unlike the usual EMDR procedure, associative processing (i.e., allowing the processing to bridge to associated memories) is discouraged with DID patients in order to keep the amount of material and its intensity at a manageable level (Fine & Berkowitz, 2001; Lazrove & Fine, 1996; Paulsen, 1995; Twombly, 2005). Instead, the target memory should be procedurally isolated as much as possible. Various techniques have been developed to modulate the intensity of EMDR work, including fractionated abreaction and serial desensitization, which involves processing the different elements of a memory held by separate self-states (Fine & Berkowitz, 2001; Lazrove & Fine, 1996; Paulsen, 2008; Rouanzoin, 2007).

Other protective modifications of EMDR for DID involve the pacing and type of alternating bilateral stimulation with highly dissociative patients. Many clinicians view the use of shorter alternating bilateral stimulation sets (Lazrove & Fine, 1996; Paulsen, 1995; Wesselman, 2000) and audio or tactile alternating bilateral stimulation as being better tolerated by dissociative patients than the use of eye movements (Bergmann, 2008; Forgash & Knipe, 2008). Longer sessions may be necessary not to expose patients to more traumatic material but rather to allow them to process and integrate material at the pace that they can tolerate and to restabilize them before concluding the session (Van der Hart et al., 2006).

Clinicians should be aware that for DID patients, the processing of a memory within most EMDR sessions will likely be incomplete. The need to revisit target memories and reprocess them may represent either the natural next step in a fraction of memory to be addressed or the patient's newly developed ability to process and integrate formerly unbearable memories—an ability achieved *because* of work in therapy thus far.

Expressive and Rehabilitation Treatment Modalities

Expressive and rehabilitation therapies are often an integral part of inpatient, partial, residential, and outpatient treatment for patients with DID (Jacobson,

1994; E. S. Kluft, 1993). Modalities such as art therapy, horticulture therapy, journaling, music therapy, movement therapy, occupational therapy, poetry therapy, psychodrama, and therapeutic recreation provide the patient with unique opportunities to address a wide range of treatment issues within a structured and supportive context.

The creative arts or expressive therapies may take place within a therapeutic dyad or a group setting. Each modality offers an alternative format through which individuals may safely communicate underlying thoughts and feelings. The nonverbal process and products (i.e., artwork, musical expression, movement sequences, writing, etc.) can serve as a visual or written record of the experiences of the internal system of alternate identities and may be examined at any point in treatment. As vital information about current stressors, triggers, safety issues, past traumatic experiences, and coping strategies is often articulated nonverbally long before it can be vocalized, expressive therapies are particularly helpful in the healing process. Subsequent discussion of artwork, writings, music, and so on can then be used to work toward a variety of treatment goals. In conjunction with verbal associations, nonverbal psychotherapeutic approaches bridge the communication gap among split-off parts of the self as well as between the patient's inner world and external reality.

In addition, expressive therapy group and individual treatment also facilitate improved concentration, reality-based thinking, internal organization and cooperation, problem-solving skills, and utilization of containment techniques. Creative therapies may promote insight, the sublimation of rage and other intense feelings, and the working through of traumatic experiences and can assist with integration goals. Many psychotherapists find the drawings and journal entries of patients useful in ongoing psychotherapy, in addition to their role in clarifying diagnostic issues. The Diagnostic Drawing Series created by Cohen, Mills, and Kijak (1994) is one of the standardized art assessments often used in making a differential diagnosis of DID. Its specificity for use with dissociative patients has also been documented (Mills & Cohen, 1993).

Rehabilitation therapies, including occupational therapy, horticulture therapy, and therapeutic recreation, are especially helpful in improving overall functioning in patients with DID. Through ongoing functional assessments and the provision of structured, reality-based crafts or tasks, the patient's ability to execute activities in a consistent and age-appropriate manner is recorded. Occupational therapy evaluations can also reveal data about how daily living, personal hygiene, meal preparation, money management, work, school, leisure/unstructured time, and social life may be adversely affected by dissociative symptoms.

Expressive and rehabilitation therapists who work in inpatient, partial, residential, and outpatient settings are typically master's- or doctoral-level clinicians and are board certified and/or registered in their respective fields; they may also have licenses in corollary mental health fields. Although

patients may bring artwork into sessions and/or clinicians may occasionally ask individuals to create art as part of a therapy assignment, the formal use of expressive and rehabilitation therapies should be practiced by clinicians with appropriate training and certification.

Sensorimotor Psychotherapy

Treatment of DID is complicated by the wide variety of disturbance in sensation, perception, autonomic regulation, and movement. Sensorimotor psychotherapy combines traditional talking therapy techniques with body-centered interventions that directly address these neurobiological and somatoform dissociative symptoms of trauma (Ogden et al., 2006). Direct somatic interventions assist the patient in regaining the ability to regulate dysregulated bodily states that contribute to dissociation. Because a person's body is a shared whole for all identities, sensorimotor psychotherapy is inherently integrative and avoids iatrogenic worsening of dissociation of the personality. Attention to the movement and sensation of the body can teach the therapist about past traumas and about the physical postures, gestures, and expressions characteristic of each identity as well as challenge these patterns. Because somatic and physiological signs are often the first signs of switching, sensorimotor interventions that alert the patient to these signs can be instrumental in helping him or her attain control over switching. The use of sensorimotor psychotherapy in a phase-oriented trauma treatment for DID necessitates an understanding of how to intervene on a bodily level for each stage of treatment: to teach somatic skills to facilitate stability and symptom reduction in Phase 1, to protect the patient's overall stability while working to complete actions and integrate traumatic memory in Phase 2, and to teach physical actions that promote further integration and adaptation in normal life in Phase 3. Emphasizing the use of "directed mindfulness," sensorimotor psychotherapy can facilitate the restoration of a witnessing self and thus can help patients identify the present-moment characteristics of identities. Unlike most body-centered therapies, sensorimotor psychotherapy includes the use of physical touch as an option but is not inherently a "hands-on" approach, making it appropriate for use with clients with dissociative disorder and easy to integrate into more traditional psychotherapeutic models. However, this approach needs to be carefully introduced and timed because of the extreme phobias that many DID patients have concerning their bodies and physical contact. Clinicians should be fully versed in the phase-oriented model of DID treatment before attempting to use sensorimotor therapy interventions.

Electroconvulsive Therapy (ECT)

ECT has not been shown to be an effective or appropriate treatment for dissociative disorders, but it may be useful in relieving a comorbid refractory

depression superimposed on DID (Bowman & Coons, 1992; DeBattista, Solvason, & Spiegel, 1998)—so-called double depression that describes a major depressive episode superimposed on a chronically depressed baseline (Klein, Taylor, Harding, & Dickstein, 1988). In double depression in DID, melancholic and/or true psychotic features are more likely to predict ECT response. Like other patients undergoing ECT, a subgroup of DID patients report significant permanent loss of autobiographical memory and ongoing memory impairment after ECT that is superimposed on (and may be difficult to differentiate from) chronic complex dissociative amnesia. Informed consent for ECT in DID should address these issues as well as the usual informed consent considerations for ECT.

Pharmacologically Facilitated Interviews

Before the development of clinical and psychometric assessment tools, hypnosis- and/or pharmacologically facilitated interviews—most commonly using amobarbital (Amytal)—were used to aid in the diagnosis and treatment of DID as well as for the differential diagnosis and treatment of acute conversion disorders and generalized dissociative amnesia, among other things (Naples & Hackett, 1978). However, the use of amobarbital and similar drugs is potentially hazardous for some patients, and side effects can include respiratory depression, sedation, hypotension, loss of coordination, and allergic reactions. In the United States, current standards set by the Joint Commission on Accreditation of Healthcare Organizations consider pharmacologically facilitated interviews to be "conscious sedation." Accordingly, these procedures can only be performed in a hospital setting with the requisite monitoring and safety standards used by the hospital's anesthesia department. Other countries may have different administrative rules about this; even so, these procedures are also uncommon outside of the United States. Thus, at this time, pharmacologically facilitated interviews are rarely performed in the diagnosis and treatment of DID.

SPECIAL TREATMENT ISSUES

Informed Consent

Clinicians should be aware of the ethical, legal, and clinical issues that are related to informed consent for mental health treatment—and for DID treatment in particular—and should take care to obtain informed consent in a manner consistent with prevailing standards of care (D. Brown et al., 1998; Courtois, 1999; Gutheil & Applebaum, 2000).

Furthermore, clinicians should educate themselves about the specific issues that have become heightened concerns because of recent controversies around trauma treatment and should consider discussing them with

patients early in treatment. Patients may become quite concerned, become distressed, or even feel betrayed if they first encounter these controversies in the media, at school, in health care settings, or from skeptics in their daily lives. These controversial issues include the traumatic versus "sociocognitive" etiology of DID, the debate over the existence of delayed recall for traumatic experiences, the possibility that therapy can produce confabulated "memories" of events that did not occur, the potential distortions and undue certainty concerning memories accessed through hypnosis, and regression and increased dependency in treatment. Even the properly conducted treatment of DID can cause temporary regressions while patients grapple with understanding their symptoms, limits and boundaries in treatment, relational issues, and the memories and emotions concerning traumatic experiences. Experienced therapists attempt to limit the duration and severity of these temporary regressions and inform patients of this possibility before addressing recollected trauma. The therapist can then proactively provide strategies to help limit the duration and severity of these temporary regressions, traumas well as to give patients more of a sense of predictability and control during treatment. There is evidence that careful informed consent and education of patients concerning controversies about the reliability of memories retrieved during hypnosis and during trauma treatment can help patients to evaluate memories that emerge during treatment and to consider them no differently than they would memories that they recall under any other circumstances (Cardeña, Maldonado, et al., 2009).

Boundary Issues in the Psychotherapy of DID

Treatment frame. Victims of child abuse or neglect—including persons with DID—have often grown up in situations in which personal boundaries were breached. In the therapy of this population, there is a significant potential for reenactments of boundary violations. It cannot be overemphasized that clinicians need to be exceedingly prudent, cautious, and thoughtful about the issue of boundaries, including the need to clearly define roles, rules, expectations, rights, and other elements of the treatment frame and the therapeutic relationship. Transference and countertransference responses with DID and related DDNOS patients are complex and changeable and must be meticulously attended to. Expert consultation can be helpful in anticipating and managing boundary-related clinical dilemmas. A fuller discussion of these issues can be found elsewhere (see Dalenberg, 2000; Davies & Frawley, 1994; Loewenstein, 1993; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994).

Boundary issues can arise at every stage in the treatment of DID, and negotiation and discussion of these issues should occur as needed. Most experts agree that the patient needs a clear statement near the beginning of treatment concerning therapeutic boundaries that might include some or

all of the following issues: length and time of sessions, fee and payment arrangements, the use of health insurance, confidentiality and its limits, therapist availability between sessions, the respective roles and responsibilities of the patient and therapist, management of inter-session crises, procedures if hospitalization is necessary, patient charts and who has access to them, physical contact between the therapist and patient, and involvement of the patient's family or significant others in the treatment, among other topics. A fuller discussion of these issues can be found elsewhere (Chu, 1998; Courtois, 1999).

At certain points in treatment, DID patients may be prone to crisis and will need clear information, ideally provided in advance, about the availability of the clinician and other resources to turn to in case of emergencies. As a general rule, offering regular or unlimited telephone contact is not helpful and may even be regressive. Yet there may be times when it is essential to provide additional availability to the patient in crisis on a predefined basis. The payment policy for telephone contact should be discussed with the patient in advance whenever possible.

Requests or attempts by DID patients to extend or alter the parameters of therapy are very common, especially from "young" alternate identities; therapists need to carefully evaluate the implications and potential effect of such requests before making any changes to the usual and customary boundaries of treatment. Experienced clinicians maintain generally consistent boundaries with all alternate identities regardless of their developmental age.

The DID patient may strongly advocate for certain changes in the boundaries or treatment frame, repeatedly requesting them or indirectly pressuring the therapist to make these changes. Rather than actually altering the treatment structure, clinicians should see these situations as opportunities to explore important clinical material. For example, efforts to change the boundaries may represent unconscious urges to reenact earlier boundary violations by significant others, conflict among alternate identities wishing to test the therapist's trustworthiness, or an attempt to compensate for unmet childhood needs.

As part of careful adherence to a well-bounded treatment frame, outpatient treatment should ordinarily take place only in the therapist's office or an appropriate location on an inpatient unit. Even in times of crisis, it is not appropriate for a patient to stay in the therapist's home, nor is it appropriate for the therapist or therapist's family members to have ongoing relationships with the patient or patient's family. Treatment usually occurs face to face. The use of an analytic couch is acceptable only for carefully screened patients being treated by therapists who have completed psychoanalytic training. Treatment should ordinarily take place at predictable times, with a predetermined session length, and despite the complexities of the treatment, clinicians should generally strive to end each session at the planned time.

Engaging in a personal relationship of any kind with the DID patient, as with other survivors of childhood maltreatment, even some time after the conclusion of treatment, is not recommended and is strongly discouraged, even though it may be permissible under the ethical codes of the therapist's professional organization and local laws and regulations.

Physical contact with patients. Physical contact with a DID patient is generally not recommended as a treatment "technique." Therapists generally need to explore the meanings of a patient's requests for a hug or hand holding, for example, rather than reflexively complying with the requests. "Reparenting" techniques such as sustained holding, simulated bottle or breast feeding, and so on are clinically inappropriate and unduly regressive behaviors that fall below the current standard of care for any patient. They have no role in the psychotherapy of DID. Some therapists believe that limited physical contact may be appropriate when a patient is highly distressed or overwhelmed, such as when the patient is intensely reliving a very disturbing experience in Phase 2 therapy. If previously and specifically discussed with the patient—that is, by full exploration with the whole alternate identity system—limited physical contact, such as briefly holding the patient's hand or resting a hand on the patient's arm, may help the patient stay connected to present-day reality. However, other therapists caution that such contact should be avoided because patients may misinterpret its intent or meaning-based past interpersonal trauma or distortions caused by intense flashbacks or memories of traumatic experiences.

Some patients may seek out massage therapy or other types of "body work" as an adjunct to psychotherapy; the risks, benefits, and timing of that decision should be carefully discussed with the patient, exploring the potential impact on the entire alternate identity system. Some DID patients have found these physical interventions helpful, particularly when the adjunctive practitioner is knowledgeable about trauma issues and careful about personal boundaries. Others patients have experienced severe intrusive PTSD symptoms, switching, and disorientation while being touched during massage therapy or any procedure involving physical contact.

Sexual contact with a current or former DID patient (or any other patient) is never appropriate or ethical.

Validity of Patients' Memories of Child Abuse

DID patients frequently describe a history of pervasive abuse beginning in childhood. Although many enter therapy remembering some abusive childhood experiences, most also recover additional previously unrecalled memories of abuse and/or additional details of partially recalled memories. Such memory recall occurs both within and outside of therapy sessions. Newly recalled trauma memories frequently precede or precipitate the patient's entry into psychotherapy (Chu, Frey, Ganzel, & Matthews, 1999).

Memories that are "recovered" (i.e., forgotten and subsequently recalled) can often be corroborated and are no more likely to be confabulated than memories always recalled (Dalenberg, 1996, 2006; R. P. Kluft, 1995, 1997; Lewis et al., 1997).

A number of professional societies have issued statements concerning recovered memories of abuse (American Psychiatric Association, 1993, 2000b; American Psychological Association, 1994, 1996; Australian Psychological Association, 1994; British Psychological Society, 1995). These reports have all concluded that it is possible for accurate memories of abuse to have been forgotten for a long time, only to be remembered much later in life. They also indicate that it is possible that some people may construct pseudomemories of abuse and that therapists cannot know the extent to which someone's memories are accurate in the absence of external corroboration—which may be difficult or impossible to obtain, especially given the passage of time. As with all memories, recall of child abuse experiences may at times mix recollections of actual events with fantasy, confabulated details, abusers' rationalizations of the events, or condensations of several events. Comprehensive discussions about the controversy around these issues can be found elsewhere (D. Brown et al., 1998; Courtois, 1999; Dallam, 2002; Freyd, 1996; Pope, 1996).

Therapy does not benefit from clinicians automatically telling patients either that their memories are likely to be false or that they are accurate and must be believed. The therapist is not an investigator, and there are ethical, boundary, and countertransference considerations related to his or her role in attempting to prove or disprove the patient's trauma history. Moreover, therapists must be careful, whatever their theoretical persuasion, not to lose sight of the patient's vulnerability to accommodate in some way to the therapist's authority in the psychotherapy relationship, the production of memories being one of them. A respectful neutral stance on the therapist's part, combined with care to avoid suggestive and leading interview techniques, along with ongoing discussion and education about the nature of memory seems to allow patients the greatest freedom to evaluate the veracity and import of their memories.

Although therapists are not responsible for determining the veracity of patients' memories, at times it may be therapeutic to communicate their professional opinion (Van der Hart & Nijenhuis, 1999). For example, if a patient has developed a well-considered belief that his or her memories are authentic, the therapist can support this belief if it appears credible and consistent with the patient's history and clinical presentation. Conversely, if the therapist has developed a well-considered and strong belief that the patient's memories are inauthentic, it may be important to voice this opinion and to provide education to the patient (e.g., concerning the vagaries of memory and recall, the presence of delusional thinking). The therapist's beliefs should not be shared with the patient in a manner or at a time

that either forecloses discussion or does not respect the patient's right to a potentially differing belief.

DID patients often are conflicted and unsure about their memories, with different alternate identities taking different points of view depending on their developmental perspective and function in the overall identity system. Accordingly, it is most helpful for the therapist to encourage the identities to explore the conflicts and differing viewpoints rather than side with any one of them. The therapist can help educate the patient about the nature of autobiographical memory (e.g., that it is generally considered reconstructive, not photographic) and about factors that can confuse memory and how these might impact a given memory report. In the early stages of treatment, when there may be greater confusion about memories, the therapist should foster a therapeutic atmosphere that encourages patients not to arrive at premature closure about the memory material, assuring them that the issues can always be reviewed again, for example after progressive integration improves the patients' access to and ability to more clearly evaluate previously dissociated information.

Organized Abuse

A substantial minority of DID patients report sadistic, exploitive, and coercive abuse at the hands of organized groups. This type of organized abuse victimizes individuals through extreme control of their environments in childhood and frequently involves multiple perpetrators. It may be organized around the activities of pedophile networks, child pornography or child prostitution rings, various "religious" groups or cults, multigenerational family systems, and human trafficking/prostitution networks. Organized abuse frequently incorporates activities that are sexually perverse, horrifying, and sadistic and may involve coercing the child into witnessing or participating in the abuse of others. Because adequate parental care and nurturing is often protective against involvement in organized abuse, individuals brought up in orphanages or related institutions may be particularly vulnerable to repetitive abuse from multiple perpetrators.

Organized abuse is typically described as long standing, and it is not unusual for its victims to report in treatment that they are still being exploited by one or more primary perpetrators. Particularly with this population, the clinician should consider the possibility that the patient may be currently being abused or may have renewed contact with abusers in the course of the treatment, which is often signaled by an unexplained shift in the therapeutic alliance or an abrupt change in the trajectory of improvement.

Victims of organized abuse—particularly ongoing abuse—are likely to be among the most traumatized dissociative patients. They are most prone to self-harm and serious suicide attempts, are very likely to be locked

in strong ambivalent attachments to primary perpetrators, and most often exhibit complex forms of DID. Some of these very traumatized patients initially have marked amnesia for much of their abuse, and the history of organized abuse emerges only with ongoing treatment.

There is a divergence of opinion in the field concerning the origins of patients' reports of seemingly bizarre abuse experiences such as involvement in occultist or satanic "ritual" abuse and covert government-sponsored mind control experiments. There are clinicians who believe that some patients' reports of such occurrences may be rooted in actual sadistic events of organized abuse experienced by these patients in childhood, whereas other clinicians believe that patients' actual experiences of extremely sadistic events in childhood may be misremembered. These latter clinicians hypothesize that the actual events are distorted or amplified because of the patient's age and traumatized state at the time of the abuse and sometimes because of deliberate attempts by the perpetrators of abuse to deceive, intimidate, or overwhelm the patient. Still other clinicians believe that alternative explanations—such as contagion, unconscious defensive elaborations, pseudomemories, delusion, or deliberate confabulation—may explain these patients' reports. Clinicians who automatically regard all such patient reports as historically true or historically false may diminish the likelihood of the patient's own exploration of such memories. As patients become more integrated, they may become more able to clarify for themselves the relative accuracy of their memories. See Fraser (1997) for a well-considered discussion of the issue of ritual abuse.

Publications and Interactions with the Media

The media and the public have long had a fascination with DID. When doing a story, media reporters commonly seek out a diagnosed individual to provide the human interest aspect of the story. Thus, clinicians working with DID patients may be approached by the media, often with the request that the clinician provide a DID patient to be interviewed. Appearances by patients in public settings with or without their therapists—especially when patients are encouraged to demonstrate DID phenomena such as switching—may consciously or unconsciously exploit the patients and can interfere with ongoing therapy. Therefore, it is generally advisable for a therapist to actively discourage patients from going public with their condition or history and to fully explore patients' fantasies and motivations about public disclosure of this type. It is helpful to provide education that, in general, patients who have made themselves known to the media have had very negative experiences, often winding up feeling additionally exploited, violated, and traumatized.

Patients' Spiritual, Religious, and Philosophical Issues

Like other victims of trauma by human agency, DID patients may struggle with questions of moral responsibility, the existential meaning of their suffering, issues of good and evil, the need for justice, and basic trust in the benevolence of the universe. When patients bring these issues into treatment, ethical standards for various professional disciplines underscore the need for the therapist not to impose his or her values on patients (e.g., that "forgiveness" of perpetrators is mandated by God, or that an appropriate treatment outcome will result in the patient believing or disbelieving in God or a Higher Power; American Psychiatric Association, 1990). When a DID patient's alternate identities are carefully explored, one often finds a range of spiritual and religious beliefs among them. Exploration of spiritual and existential issues can be fruitful in DID therapy and may result in a deepening of the therapeutic work. Education and coordination between the therapist and clergy can be helpful in ensuring that patients' religious and spiritual needs are addressed (Bowman & Amos, 1993; Rosik, 1992). It is helpful to find clergy that are knowledgeable about and sensitive to the complex spiritual questions raised by patients' experiences of extreme trauma and betrayal.

Although patients may experience certain parts of themselves as demonic figures—and occasionally positive spiritual entities such as angels or saints—and as "not-self," clinicians should regard these entities as alternate identities, not supernatural beings. Names of alternate identities such as "Devil" or "Satan" may reflect patients' concrete culture-bound stereotyping of their self-aspects using religious terminology rather than evidence of a demonic presence. Malevolently labeled self-states also may reflect specific spiritual and/or religious abuse, such as abuse by clergy and/or projection of blame by the abuser. For example, a child may be told that punishment is necessary because he or she "is filled with the devil." The child may encapsulate forbidden behaviors and affects in a malevolently named "other" identity, thereby preserving a sense of self as "good."

Therapists should approach with extreme caution the wish of DID patients or their concerned others for an exorcism ritual. Such rituals have not been shown to be an effective treatment for DID and have not been shown to be effective for permanently "removing" alternate identities, despite the apparent disappearance (dissociation from the remainder of the alternate identities) of "demonic" identities during an exorcism. Deleterious effects from exorcism rituals conducted outside of psychotherapy have been found in two samples of DID patients who experienced them. Some Guidelines Task Force members have noted that, in rare cases, noncoercive exorcism rituals may provide a way for some patients to rearrange images of their identity systems in a culturally syntonic manner (Bowman, 1993; Fraser,

1993; Rosik, 2004). Other task force members do not believe that exorcism is ever an appropriate intervention for DID patients.

Ignoring the religious and spiritual concerns of DID patients is not recommended. Therapists who feel unable to adequately address these matters may refer their patients to clergy trained in working with DID or severely traumatized persons and may communicate with the clergy to coordinate treatment approaches (Bowman, 1989; Bowman & Amos, 1993; Rosik, 1992).

DID Patients as Parents

DID patients have been shown to have a wide range of competence as parents—from exemplary to abusive (R. P. Kluft, 1987b). Clinicians should be aware of the potential for a DID parent to be neglectful or abusive when in particular dissociative states or because of life problems associated with this disorder (e.g., depression, fear of being assertive). Abuse and neglect can include permitting children to be exposed to abusive family members—either the DID patient's family of origin or abusive partners—subjecting children to witnessing domestic violence or acts of self-harm, and so on.

The therapist should actively assess these issues and then offer assistance with parenting behavior. Work on the safety of the patient's children should be an absolute priority in the adult patient's treatment. The patient may need extensive education about how to function appropriately as a parent, including work with alternate identities who deny that they are parents and/or refuse to acknowledge the needs of their children. Patients must be encouraged to be in an adult identity state when with their children, not to switch openly in front of them, and not to regress into child identity states in order to play with them. When indicated, the children of DID patients should be assessed by a therapist familiar with dissociative disorders and indicators of child abuse. Other family interventions, such as couples therapy and family therapy sessions that include the patient's children, may be indicated. However, caution should be exercised in determining what information is shared with minor children concerning the patient's DID diagnosis, depending on the age of the children and their cognitive and emotional development.

At times, following state/jurisdictional law, the clinician may need to report to the authorities abuse, or possible abuse, of children by the patient, members of the patient's current family, members of the family of origin, or extrafamilial perpetrators. The therapist should act vigorously to protect the DID patient's children from abuse or neglect, even if this means a rupture of the therapeutic relationship. In general, having the patient make the report together with the therapist may be the most clinically helpful intervention for the patient. Whenever possible, the patient (and his or her spouse or partner) should be advised of this possibility or necessity ahead of time.

CONCLUSIONS

The information in these *Guidelines* represents current and evolving principles that reflect current scientific knowledge and clinical consensus developed over the past 30 years with regard to the diagnosis and treatment of DID. Given that ongoing research on the diagnosis and treatment of dissociative disorders and other related conditions such as PTSD will lead to further developments in the field, clinicians are advised to continue to consult the published literature to keep up with important new information. It is strongly recommended that therapists treating DID and other dissociative disorders have proper training in their diagnosis and treatment, for example through programs available through the ISSTD.

NOTES

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